PATIENT INFORMATION

Patient's Name _____Date ___/___/_____
Birth Date ___/___/_____ Age _____ SSN ___/__/_____
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Home Address _____Phone (___) ____-_____
City/State/ZIP _____
E-mail address _____

Employer_____Occupation_____
Business Address_____ Phone (___) ____-_____
City/State/ZIP _____

Spouse/Partner Name _____Spouse/Partner Employer _____
Person Responsible for Account: _____
Address _____City/State/ZIP _____
Name of nearest relative not living with you: _____
Address _____City/State/ZIP _____

Whom may we thank for referring you: _____

If Patient Is A Minor: I hereby grant permission for dental work to be performed on this minor and will assume all responsibilities connected with such treatment.

Signature of Parent or Guardian_____

DENTAL HISTORY

Name _____

Reason for Today's Visit _____

Please Check (☑)	***Yes / No***		***Yes/No***		***Yes/No***	
Sensitivity to hot/cold	☐	☐	Cigarette/pipe/smoking (___ yrs.)	☐ ☐	Crowded teeth	☐ ☐
Gum disease	☐	☐			Bad breath	☐ ☐
Sore on lips or in mouth	☐	☐	Chew tobacco	☐ ☐	Food collection	☐ ☐
Dry mouth	☐	☐	Chew on one side only	☐ ☐	Swelling around teeth	☐ ☐
Bleeding gums	☐	☐	Grinding teeth	☐ ☐	Broken fillings	☐ ☐
Jaw pain	☐	☐	Mouth breathing	☐ ☐	Loose teeth	☐ ☐
Discolored teeth	☐	☐	Lip or cheek biting	☐ ☐	Braces	☐ ☐

Are you interested in: ☐ bleaching? ☐ veneer? ☐ straighter teeth?

What would you change about your smile? _____

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MEDICAL HISTORY

Name (please print) _____

Name of medical provider: _____ phone # _____
Are you taking medication at this time? ☐ Yes ☐ No
If so, please list and provide dosage. _____
_____
Are you allergic to : ☐ Penicillin ☐ Codeine ☐ Dental anesthetic ☐ Metals/other materials
Are you susceptible to latex allergies? ☐ Yes ☐ No
Do you have any other allergies we should be aware of? _____
Are you pregnant or think you are pregnant? ☐ Yes ☐ No Estimated due date: ___/___/_____
Are you subject to ☐ prolonged bleeding ☐ fainting spells ☐ excessive urination or thirst
Have you ever had any type of radiation therapy (other than diagnostic)? ☐ Yes ☐ No

Please Check (☑)	***Yes / No***		***Yes / No***	
Abnormal blood pressure	☐	☐	Heart pacemaker	☐ ☐
Arthritis or Rheumatism	☐	☐	Mitral valve prolapsed	☐ ☐
Artificial joints	☐	☐	Hepatitis	☐ ☐
Date of surgery: ___/___/_____			HIV/AIDS	☐ ☐
Asthma or hay fever	☐	☐	Jaundice	☐ ☐
Blood disease or anemia	☐	☐	Kidney disorder	☐ ☐
Chemotherapy	☐	☐	Leukemia	☐ ☐
Chronic cough	☐	☐	Multiple sclerosis	☐ ☐
Cold sores or fever blisters	☐	☐	Parkinson's	☐ ☐
Congenital heart lesions	☐	☐	Psychiatric treatment	☐ ☐
Diabetes	☐	☐	Rheumatic fever	☐ ☐
Epilepsy	☐	☐	Sinus trouble	☐ ☐
Frequent canker cores	☐	☐	STDs	☐ ☐
Glaucoma	☐	☐	Stroke	☐ ☐
Head injury	☐	☐	Thyroid condition	☐ ☐
Heart disease	☐	☐	Tuberculosis or lung disease	☐ ☐
Heart murmur	☐	☐	Tumors or growths	☐ ☐
			Ulcers	☐ ☐

Any other medical problems we need to be aware of: _____

Signature_____ Date ____/____/_____

Please initial and date below indicating you have reviewed and updated your health history:

Initials _____ Date ____/____/_____ Initials _____ Date ____/____/_____

Initials _____ Date ____/____/_____ Initials _____ Date ____/____/_____