

# Patient information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please don't hesitate to ask.

Patient name \_\_\_\_\_ Today's date \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Driver's license number \_\_\_\_\_ State \_\_\_\_\_

Home address \_\_\_\_\_

Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email address \_\_\_\_\_

Billing address (if different from above) \_\_\_\_\_

Employer/occupation \_\_\_\_\_ Business phone \_\_\_\_\_

Spouse's name \_\_\_\_\_ Spouse's phone \_\_\_\_\_

Emergency contact and phone (other than spouse) \_\_\_\_\_

Primary dental insurance \_\_\_\_\_ Group number \_\_\_\_\_

Secondary dental insurance \_\_\_\_\_ Group number \_\_\_\_\_

Subscriber's name \_\_\_\_\_

Subscriber's insurance number \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Name of your medical doctor \_\_\_\_\_

Date of last visit to medical doctor \_\_\_\_\_

Name of previous dentist \_\_\_\_\_

Date of last visit to dentist \_\_\_\_\_

Referred to us by \_\_\_\_\_

### Dental health history

Do you have or have you had any of the following?

(check all that apply)

- Apprehension about dental treatment
- Problems with previous dental treatment
- Gag easily
- Wear dentures
- Food catches between your teeth
- Difficulty chewing your food
- Chew on only one side of your mouth
- Avoid brushing any part of your mouth because of pain
- Gums bleed easily
- Gums bleed when flossing
- Gums feel swollen or tender
- Notice slow-healing sores in or around your mouth
- Feel twinges of pain when your teeth come into contact with:
  - Hot foods or liquids
  - Cold foods or liquids
  - Sour foods
  - Sweet foods
- Take fluoride supplements
- Feel dissatisfied with the appearance of your teeth
- Want to save your teeth?
- Want complete dental care?
  - How often do you brush? \_\_\_\_\_
  - How often do you floss? \_\_\_\_\_
- Your jaw makes noise so that it bothers you
  - Or others
- Clench or grind your teeth frequently
- Jaws feel tired
- Jaw gets stuck so that you can't open freely
- Pain when you chew or open wide to take a bite
- Earaches or pain in front of your ears
- Jaw symptoms or headaches upon awaking in the morning
- Jaw pain or discomfort affecting your appetite, sleep, daily routine, or other activities
- Jaw pain or discomfort that is extremely frustrating or depressing
- Take medications for pain or discomfort (pain relievers, muscle relaxants, antidepressants)
- Temporomandibular (jaw) disorder (TMD)
- Pain in the face, cheeks, jaws, joints, throat, or temples
- Unable to open your mouth as far as you want
- Aware of an uncomfortable bite
- Had a blow to the jaw (trauma)
- Habitually chew gum?
- Smoke?  Pipe?  Other? \_\_\_\_\_
- Use chewing tobacco?

**Medical health history**

Do you have or have you had any of the following?  
(check all that apply)

- Heart problems
- Chest pain
- Shortness of breath
- Blood pressure problem
- Heart murmur
- Heart valve problem
- Taking heart medication
- Rheumatic fever
- Pacemaker
- Artificial heart valve
- Blood problems
- Easy bruising
- Frequent nosebleed/abnormal bleeding
- Blood disease
- Anemia
- Ever require a blood transfusion?
- Allergy problems
- Hay fever
- Sinus problems
- Taking allergy medication
- Asthma
- Intestinal problems
- Ulcers
- Weight gain or loss
- Special diet
- Constipation/diarrhea
- Kidney or bladder problems
- Fainting spells, seizures or epilepsy
- Stroke(s)
- Frequent or severe headaches
- Thyroid problems
- Persistent cough or swollen glands
- Pre-medications required by physician
- Cancer/tumor
- Diabetes
- Urinate more than six times a day
- Thirsty or mouth is dry much of the time
- Family history of diabetes
- Tuberculosis or other respiratory disease
- Bone or joint problems
- Arthritis
- Back or neck pain
- Joint replacement (e.g. hip, pins, implants)
- Other disease, condition or problem not listed above: \_\_\_\_\_

- Drink alcohol or use recreational drugs?  
If so, how much? \_\_\_\_\_
- Hepatitis, jaundice or liver trouble
- Herpes or other STD
- HIV positive/AIDS
- Glaucoma
- Do you wear contact lenses?
- Head injury
- Epilepsy or other neurologic disease
- History of alcohol or drug abuse
- During the past 12 months, have you taken any of the following?
- Antibiotics or sulfa drugs
- Anticoagulants (e.g. Coumadin)
- High blood pressure medicine
- Tranquilizers
- Insulin, Tolbutamide or similar drug
- Aspirin
- Digitalis or drugs for heart trouble
- Nitroglycerin
- Cortisone (steroids)
- Natural remedies
- Nonprescription drug/supplements
- Other: \_\_\_\_\_

Are you allergic or have you reacted adversely to any of the following?

- Local anesthetics (Novocain)
- Penicillin or other antibiotics
- Sulfa drugs
- Barbiturates, sedatives or sleeping pills
- Aspirin, acetaminophen or ibuprofen
- Codeine, Demerol or other narcotics
- Metals
- Latex or rubber dam
- Other: \_\_\_\_\_
- What medications are you currently taking?  
taking? \_\_\_\_\_  
\_\_\_\_\_

**Women**

- Are you taking contraceptives or other hormones?
- Are you pregnant?
- If so, expected delivery date \_\_\_\_\_
- Are you nursing?
- Have you reached menopause?
- If so, do you have symptoms?

\_\_\_\_\_  
Patient signature/legally authorized representative and relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor signature

\_\_\_\_\_  
Date