

Name: _____ Birth Date: _____ SS#: _____

I prefer to be called: _____ Driver's License #: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone – Residence: _____ Business: _____

Cell Phone: _____ Email Address: _____

Employed by: _____ Occupation: _____ How Long: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Husband or Wife's Name: _____ Employed by: _____

Business Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____

Whom may we thank for referring you to our office? _____

If you are completing this form for another person, what is your relationship to that person? _____

In the following questions, mark YES or NO, whichever applies. Your answers are for our records only and will be considered confidential.

Yes No

- 1. Are you in good health?
- 2. Has there been any change in your general health withing the past year?
- 3. My last physical examination was on: _____
- 4. Are you now under the care of a physician?
If so, what is the condition being treated? _____
- 5. The name and address of my physician is: _____
- 6. Have you had a serious illness or operation?
If so, what is the illness or operation? _____
- 7. Have you been hospitalized or had a serious illness within the past five (5) years?
If so, what was the problem? _____
- 8. Are you currently taking any medication(s) or non-prescription medicine?
If so, what medicine(s) are you taking? _____
Prescribed: _____
Over the Counter: _____
Natural or Herbal Preparations: _____
- 9. Are you alcohol or drug dependent?
If so, have you received treatment? _____
- 10. Do you use tobacco (smoking, snuff, chew)?
If so, what degree is your interest in stopping? very interested somewhat interested not interested
- 11. Do you wear contact lenses? _____
- 12. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
If so, when was the operation done? _____
- 13. Have you had any complication or difficulties with your prosthetic joint?
- 14. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
Name of physician or dentist (if different from above): _____
Phone number: _____
- 15. Women Only**
 - Are you pregnant?
 - Nursing?
 - Taking birth control pills?

Allergies

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Iodine
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Seasonal
<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates, Sedatives, Sleeping Pills	<input type="checkbox"/>	<input type="checkbox"/>	Food
<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Codeine or other Narcotics			

Please (X) if you have or had any of the following diseases or problems.

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Disease, Drug, or Radiation Induced Immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes. If yes, specify below:			If yes, specify below:
<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Type I (Insulin Dependent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Type II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bronchitis, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Severe Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	Severe or Rapid Weight Loss
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease
		If yes, date: _____	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy/Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Sores or Ulcers in the Mouth
		If yes, specify below:	<input type="checkbox"/>	<input type="checkbox"/>	G.I. Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
		<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus Erythematosus
		<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
		<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, Jaundice or Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
		<input type="checkbox"/> Coronary Insufficiency	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
		<input type="checkbox"/> Coronary Occlusion	<input type="checkbox"/>	<input type="checkbox"/>	Indicate type of Infection: _____	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Urination
		<input type="checkbox"/> Damaged Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Do you have any disease, condition or problem not listed above that you think I should know about?
		<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	Please explain: _____		
		<input type="checkbox"/> Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	_____		
		<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Disorders	_____		
		<input type="checkbox"/> Inborn Heart Defects	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify: _____	_____		
		<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>		_____		
		<input type="checkbox"/> Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition	_____		
		<input type="checkbox"/> Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain Upon Exertion	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disorders	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify: _____	_____		

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

For Completion by Dentist

Comments on patient interview concerning health history: _____

Dental management considerations: _____

Signature of Dentist: _____ Date: _____

Dental History

Name _____ Date _____

Thank you for considering our practice. How can we help you? _____

Do you have any discomfort when you chew or bite? Yes No If yes, where? When? _____

Do you have any teeth which are sensitive to hot, cold or sweets? Yes No If yes, when? Where? _____

Are you having any other problems with your *teeth* at this time? _____

How often do you typically have your teeth examined and cleaned? _____

When was the last time you had a complete set of dental x-rays? _____

Have you had much dental treatment in the past? Yes No If yes, please briefly describe what has been done: _____

Do you have any concerns about the type or quality of dental care you have received in the past? Yes No

If yes, explain: _____

Are you missing any teeth? Yes No If yes, do you regret losing any of them? Yes No

Have you ever worn braces? Yes No If yes, when? For how long? _____

Does your bite feel comfortable? _____

Can you chew as well as you would like to? _____

Are you satisfied with the appearance of your teeth? Yes No If no, what is it that you do not like about your

teeth/smile? _____

What is your typical daily oral hygiene routine? _____

Do your gums bleed when you brush your teeth? Yes No

How often do you suffer from bad breath? Rarely Occasionally Often

Do you use gum, breath mints, or cough drops? Never Occasionally Often

Have you ever been told you have gum disease? _____

Have you ever been treated for gum disease? _____

Did your parents have gum disease? _____

Did/do your parents wear dentures? _____

Do your jaw joints ever click, pop, hurt or lock-up? _____

Have you ever been treated for "TMJ"? _____

Would you consider your daily diet to be: Healthy Good Could be better

Do you exercise regularly? Yes No If yes, what do you typically do? _____

Do you usually awaken well rested after a full night's sleep? Yes No

Do you use tobacco products? Yes No I use: _____

How much of a priority is it for you to keep your natural teeth over your lifetime?

very high priority somewhat high not sure yet low priority

How would you rate your current dental health?

	Perfect		Good		Fair		Poor		Hopeless	
(circle one)	10	9	8	7	6	5	4	3	2	1

How do you feel about visiting our office today?

excited hopeful concerned afraid other: _____

What concerns you most about visiting the dentist? _____

What elements of dental care are your top priorities at this time? (please check)

- Clean your teeth
- Identify and address current problems.
- Work with you to create long-range strategies which can create and maintain the health of your teeth and smile over your lifetime.
- Work with you to identify ways to improved the appearance of your teeth/smile.

Optional

We know that excessive stress can negatively influence all aspects of your health.

What do you feel are the biggest sources of stress you are facing these days? _____

