# WELCOME

*Welcome to our office! We appreciate your confidence in our dental health team and pledge to provide you with the highest level of personal, professional care. In order to help us ensure your health and comfort, we ask that you complete the following form. All information will be held in the strictest confidence. The information provided is important to your dental health. If you have any questions, please ask and we will be happy to assist you.*

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

❑ Internet ❑ Other_____

## PATIENT INFORMATION

Title: ❑Dr. ❑Miss ❑Mrs. ❑Ms. ❑Mr. Today's Date_____

Patient's name _____ Birth date _____/____/_____ Male or Female

Preferred name _____ Social Security #_____

If patient is a minor, parent's name_____ Home phone (_____)_____

Cell phone (_____)_____ Do you text? ❑Yes ❑No Work Phone (_____)_____ Ext_____

E-mail _____ Would you like to receive an e-mail to confirm your appointments? ❑ Yes ❑ No

Address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

Spouse/Partner's name _____ ❑ Unmarried

**If patient is a minor** (under the age of 18 years), who is the primary parent/guardian giving consent for our office to treat the minor?

Parent/Guardians Name_____ Signature_____

Address _____ City_____ State_____ Zip_____

Telephone_____

**Primary Dental Insurance Co**._____ ID # _____

Group#_____

Employer _____ Subscriber's name_____ Date of Birth ____/____/_____

Social Security Number _____

**Secondary Dental Insurance Co**._____ ID # _____

Group#_____

Employer _____ Subscriber's name_____ Date of Birth ____/____/_____

Birthday _____/_____/_____ Social Security Number _____

## DENTAL HISTORY: CHECK "YES" OR "NO" TO INDICATE IF YOU HAVE EVER HAD ANY OF THE FOLLOWING

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Bad Breath (halitosis) | ❑Yes | ❑No | Food Collection Between Teeth | ❑Yes | ❑No | Sores or Growth In Mouth | ❑Yes | ❑No |
| Bleeding Gums when Brushing or Flossing | ❑Yes | ❑No | Jaw Pain or Tenderness | ❑Yes | ❑No | | | |
| Blisters on Lips or Mouth | ❑Yes | ❑No | Loose Teeth | ❑Yes | ❑No | Snoring and/or Sleep Apnea | ❑Yes | ❑No |
| Broken Fillings | ❑Yes | ❑No | Mouth Breathing | ❑Yes | ❑No | | | |
| Clenching or Grinding Teeth | ❑Yes | ❑No | Orthodontic Treatment | ❑Yes | ❑No | How Often Do You Floss?_____ | | |
| | | | Periodontal Treatment | ❑Yes | ❑No | | | |
| Clicking or Popping Jaw | ❑Yes | ❑No | Sensitivity to Hot, Cold Sweet or Biting | ❑Yes | ❑No | How Often Do You Brush?_____ | | |
| Dry Mouth | ❑Yes | ❑No | | | | | | |

**ARE YOU PLEASED WITH THE WAY YOUR TEETH LOOK?** ❑Yes ❑No

If no, what changes would you make? _____

_____

# MEDICAL HEALTH HISTORY

Name of your physician:_____ City_____ State_____ Phone_____

Has your physician ever said you should take an antibiotic before dental procedures? ❑Yes ❑No If yes, what for_____

Have you been hospitalized in the past two years? ❑Yes ❑No If yes, why_____

Have you been under the care of a medical doctor in the past two year (other than routine physicals)? ❑Yes ❑No
If yes, why_____

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

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hay fever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

**Medications:** Please list medications you are currently taking, be sure to include any non- prescription medications as well.

_____
_____
_____
_____

Have you ever taken Fosomax, Actenol, Reclast, Aredia, Zometa, Didronel, Boniva, Skelid, Prolia? ❑ yes ❑ no

If yes, please circle above and tell us how long you took it, if no longer taking it, how many years since you took it?

_____
_____

**Allergies:**

- ❑ Aspirin
- ❑ Codeine
- ❑ Penicillin
- ❑ Latex
- ❑ Local Anesthetic
- ❑ Metals
- ❑ Other:_____

**Women only:** Are you, or do you think you may be pregnant? ❑Yes ❑No If yes, approximate due date_____
Are you currently nursing? ❑Yes ❑No Are you currently taking oral contraceptives? ❑Yes ❑No

Is there any other information concerning your health that we should know?_____

_____

**Health History Updates:**

I hereby state that the above information is correct and complete to the best of my knowledge.

Signature(or parent) _____ Date _____ Signature(or parent) _____ Date _____

Signature(or parent) _____ Date _____ Signature(or parent) _____ Date _____

Signature(or parent) _____ Date _____ Signature(or parent) _____ Date _____

Signature(or parent) _____ Date _____ Signature(or parent) _____ Date _____