PERSONAL HISTORY

Name _____ Date _____

Home Address _____ City _____ Zip _____

Home Phone _____ Birthdate _____ Sex _____

Cell Phone _____ Email _____

Social Security No. _____ Martial Status _____

Employer _____ Occupation _____

Bus. Address _____ City _____ Zip _____

Bus. Phone _____

Spouse's Name _____ Spouse's Employer _____

Bus. Address _____ City _____ Zip _____

Bus. Phone _____

Who should we call in an emergency? _____ Phone _____

Person responsible for Account _____

How did you hear about our office? _____

Are you covered by a Dental Insurance plan? Yes____ No____

If yes, Name of Company _____ Group No. _____

Subscriber's name _____ Birthday _____

DENTAL INFORMATION

1. Reason for visit: _____

_____

2. Date of last treatment: _____

3. Date of last teeth cleaning: _____

4. How often do you brush? _____

5. How often do you floss? _____

Yes	No	
☐	☐	6. Do you supplement your diet with fluoride?
☐	☐	7. Are you having pain at this time?
		8. Have you had:
☐	☐	a. orthodontic treatment (braces)?
☐	☐	b. oral surgery? (wisdom teeth)
☐	☐	c. gum treatment?
☐	☐	d. your teeth ground or the bite adjusted?
☐	☐	e. or worn a bite plane or other appliance?
☐	☐	9. Have you noticed any loosening of your teeth?
☐	☐	10. Does food tend to become caught between your teeth?
☐	☐	11. Do your gums often bleed when you brush your teeth?
☐	☐	12. Do you have any sores or lumps in or near your mouth?
☐	☐	13. Are you dissatisfied with the function of your teeth?
		14. Problems of the jaw. Have you ever experienced:
☐	☐	a. clicking of the jaw?
☐	☐	b. pain (joint, ear, side of face)?
☐	☐	c. difficulty in opening and closing?
☐	☐	d. difficulty in chewing?

Family & Cosmetic
DENTISTRY
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Advanced dental care for a healthy, beautiful smile

Yes	No	
☐	☐	15. Have you had any head, neck, or jaw injuries?
		16. Habits. Do you.
☐	☐	a. clench or grind your teeth while awake or asleep?
☐	☐	b. bite your lips or cheeks frequently?
☐	☐	17. Have you ever had an upsetting experience in the dental office?
☐	☐	18. Is it important to you to keep your teeth?
☐	☐	19. Are you dissatisfied with the appearance of your smile?
☐	☐	20. Is there anything about having dental treatment that bothers you?
		21. Previous dentist _____

If yes to any of the above, please explain:

_____

_____

MEDICAL INFORMATION

Yes	No	
☐	☐	1. Has there been any change in your general health within the past year?
☐	☐	2. Your last physical examination was on: _____
☐	☐	3. Are you now under care of a physician?
☐	☐	4. Name, address, and phone no. of physician is: _____ _____ _____
☐	☐	5. Have you been hospitalized for any surgical operation or serious illness?
		6. Do you have or have you had any of the following diseases or problems:
☐	☐	a. rheumatic fever, scarlet fever, or rheumatic heart diseases?
☐	☐	b. heart defect or heart murmur?
☐	☐	c. heart trouble, heart attack, or angina?
☐	☐	(1) do you have pain in your chest upon exertion?
☐	☐	(2) are you ever short of breath after mild exercise?
☐	☐	(3) do your ankles swell?
☐	☐	(4) do you get short of breath when you lie down, or do you require extra pillows when you sleep?
☐	☐	(5) artificial heart valve
☐	☐	(6) mitral valve prolapse

Yes	No		Yes	No	
☐	☐	d. pacemaker?			11. Are you taking any of the following:
☐	☐	e. heart surgery?	☐	☐	a. antibiotics or sulfa drugs?
☐	☐	f. high blood pressure?	☐	☐	b. anticoagulants (blood thinners)?
☐	☐	g. stroke?	☐	☐	c. medicine for high blood pressure?
☐	☐	h. hepatitis?	☐	☐	d. cortisone (steroids)?
☐	☐	i. sinus trouble?	☐	☐	e. tranquilizers?
☐	☐	j. lung or breathing problems?	☐	☐	f. dilantin?
☐	☐	k. asthma or hay fever?	☐	☐	g. antihistamines?
☐	☐	l. hives or skin rash?	☐	☐	h. aspirin?
☐	☐	m. fainting spells or seizures?	☐	☐	i. insulin, tolbutamide (orinase), or other drug to control blood sugar?
☐	☐	n. diabetes?	☐	☐	j. digitalis or drugs for heart trouble?
☐	☐	(1) do you have to urinate more than 6 times a day?	☐	☐	k. nitroglycerin?
☐	☐	(2) are you thirsty much of the time?	☐	☐	l. oral contraceptives?
☐	☐	(3) does your mouth often become dry?	☐	☐	Other: _____
☐	☐	o. allergies?	☐	☐	12. Are you allergic to or have you had reactions to:
☐	☐	p. liver disease or jaundice?	☐	☐	a. local anesthetic like novocaine?
☐	☐	q. thyroid problems?	☐	☐	b. penicillin or other antibiotics?
☐	☐	r. arthritis, rheumatism?	☐	☐	c. sulfa drugs?
☐	☐	s. joint replacement or implant?	☐	☐	d. barbiturates, sedatives, or sleeping pills?
☐	☐	t. stomach ulcers?	☐	☐	e. aspirin?
☐	☐	u. kidney trouble, kidney transplant or dialysis?	☐	☐	f. iodine?
☐	☐	v. tuberculosis?	☐	☐	g. latex?
☐	☐	(1) do you have a persistent cough or cough up blood?	☐	☐	Other: _____
☐	☐	w. low blood pressure?	☐	☐	13. Have you had any trouble associated with a previous dental treatment?
☐	☐	x. do you use tobacco?	☐	☐	14. Does anyone in your family have any disability, birth defects, or growth related problems?
☐	☐	y. chemical dependency (drugs, alcohol)?	☐	☐	15. Herpes?
☐	☐	z. veneral disease?	☐	☐	16. Do you have any disease, condition, or problem not listed above that you think I should know about?
☐	☐	Other:_____	☐	☐	17. Have you had an Aids/HIV test? ☐ positive ☐ negative
☐	☐	7. Have you had abnormal bleeding associated with previous tooth extractions, surgery, or injuries?	☐	☐	18. Women:
☐	☐	a. do you bruise easily?	☐	☐	a. are you pregnant or think you might be pregnant?
☐	☐	b. have you ever required a blood transfusion?	☐	☐	b. are you nursing presently?
☐	☐	8. Do you have any blood disorders such as anemia or leukemia?			
☐	☐	9. Do you have any eye problems such as glaucoma?			
☐	☐	10. Have you had surgery or X-ray treatment for a tumor, growth, or other condition of your mouth or lips?			

Personal Representative or other individual that we may discuss your treatment with.

Name _____

Relationship_____Initial_____

If yes to any of the above, please explain:

_____

_____

Signature _____Date _____

(Patient or parent/guardian if patient is under age 18)

The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ Date_____

Authorized Signature of Covered Person/Employee