** *Welcome!***

**Patient Information**

|  |  |
| --- | --- |
| Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Preferred Name\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_ |
| Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patient Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patient’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Present Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Spouse’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Present Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Will the fees for our services be offset by dental insurance? | Yes / No |
| Subscriber Name/DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dental Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Identification#/SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Who may we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**Dental History**

What prompted you to seek dental care at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has it been since your last dental visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last complete x-ray exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you last have your teeth cleaned? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you planning to keep your remaining teeth your whole lifetime? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has fear of discomfort kept you from regular dental care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Have you ever had any of the following dental procedures done? If so, please explain.*

Gum Treatments or Periodontal Surgery? Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Orthodontic Treatment? Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Oral Surgery? Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Endodontic Treatment? Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever whitened your teeth? Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you interested in whitening? Yes/No \_\_\_\_\_\_\_\_\_\_\_\_

*Do you have or have you had any of the following:*

|  |  |  |
| --- | --- | --- |
| \_\_\_ Bleeding/sore gums | \_\_\_ Unpleasant breath | \_\_\_ Dry mouth |
| \_\_\_ Sensitivity to hot/cold | \_\_\_ Sensitivity to biting pressure | \_\_\_ Sensitivity to sweets |
| \_\_\_ Frequent sores or blisters | \_\_\_ Burning tongue or lips | \_\_\_ Swelling/lumps in the mouth |
| \_\_\_ Clicking/popping jaws | \_\_\_ Pain or soreness of jaw joint | \_\_\_ Clenching/grinding your teeth |
| \_\_\_ Loose teeth | \_\_\_ Shifting of teeth/change in bite | \_\_\_ Difficulty opening/closing jaw |
| \_\_\_ Frequent cavities | \_\_\_ Build up a lot of plaque/calculus | \_\_\_ Areas where food gets caught |

How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other products/rinses do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you could change anything about your teeth or smile, what would it be? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything we can do to make your dental appointment more comfortable? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other dental concerns you’d like to discuss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I certify that the above information is complete and accurate.***

**Patient/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dentist’s Initials \_\_\_\_\_\_\_\_\_** *Please Complete Reverse Side.*

**Medical History**

*Please take the time to complete this form with your current medical information. Your medical history can influence your susceptibility to certain dental conditions. Please inform us of any medical changes in the future.*

Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a physician? Yes / No Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please check and/or circle any of the following conditions that you have or have had in the past:*

|  |  |  |
| --- | --- | --- |
| \_\_\_ Abnormal Bleeding | \_\_\_ Epilepsy or Seizures | \_\_\_ Nervous Problems |
| \_\_\_ Anemia/Blood Disorders | \_\_\_ Fainting or Dizzy Spells | \_\_\_ Organ Transplant, Type: \_\_\_\_\_\_\_ |
| \_\_\_ Angina (Chest Pain) | \_\_\_ Frequent Headaches, Neck or | \_\_\_ Osteoporosis/Osteopenia |
| \_\_\_ Any Heart Problems | Shoulder Aches | \_\_\_ Radiation/Chemotherapy |
| \_\_\_ Arthritis/Rheumatism | \_\_\_ Glaucoma or Light Sensitivity | \_\_\_ Rheumatic Fever |
| \_\_\_ Artificial Heart Valve/Pacemaker | \_\_\_ Heart Murmur | \_\_\_ Sinus Problems |
| \_\_\_ Asthma/Hay Fever | \_\_\_ Hepatitis, Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ Stroke |
| \_\_\_ Blood Pressure: High or Low | \_\_\_ Herpes/Cold Sores/Shingles | \_\_\_ Tested Positive for HIV |
| \_\_\_ Cancer, Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ Joint Replacement \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ Thyroid: Hypothyroid/Hyperthyroid |
| \_\_\_ Diabetes: Type 1 or Type 2 | When? \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ Tuberculosis |
| -Controlled or Uncontrolled?  -By Medication or Diet? | \_\_\_ Kidney/Liver Problems  \_\_\_ Mental/Emotional Disorders | \_\_\_ Venereal Disease |

Have you had a serious disease not listed above? Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken Bisphosphonate medications (Fosamax, Boniva, Prolia, Zometa)? Yes / No

*If yes, which medication?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Do you smoke, chew, use snuff, or any other forms of tobacco? Yes / No *Circle those that apply.*

*How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you interested in quitting? \_\_\_\_\_\_\_\_*

Do you consume alcohol or use recreational drugs? Yes / No *Circle those that apply.*

*How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Have you been told you require a premedication before dental appointments? Yes / No \_\_\_\_\_\_\_\_\_\_\_

Please list any medications you are currently taking (prescription, non-prescription, supplements etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to or have you had any reaction to:

|  |  |
| --- | --- |
| \_\_\_ Local Anesthetics (Lidocaine, etc) | \_\_\_ Aspirin / Codeine |
| \_\_\_ Latex | \_\_\_ Hydrogen Peroxide |
| \_\_\_ Penicillin / Amoxicillin | \_\_\_ Ibuprofen |
| \_\_\_ Erythromycin | \_\_\_ Nickel / Other Metals |
| \_\_\_ Sulfa Drugs | \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Women only:** Are you pregnant? Yes / No

Are you nursing? Yes / No

***I certify that the above information is complete and accurate.***

**Patient/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**

**Dentist’s Initials \_\_\_\_\_\_\_\_\_\_**