

Welcome

*Please take a few minutes to answer the following questions
so we can better assist you with your dental needs*

Patient Information

Patients Name _____ Birthdate _____

Male _____ Female _____ Social Security Number _____

If Child, Parent's Names _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail Address _____

Employer _____

Spouse's Name _____

Emergency Contact _____ Relationship _____ Phone Number _____

Whom may we thank for this referral _____

Insurance

Primary Insurance _____ Phone _____

Person Responsible for Account _____ Birthdate _____ SS# _____

Responsible Party Employed By _____ Relationship to Patient _____

Secondary Insurance _____ Phone _____

Person Responsible for Account _____ Birthdate _____ SS# _____

Responsible Party Employed By _____ Relationship to Patient _____

Patient or Guardian Signature _____ Date _____

Patient Name _____

Dental History

Purpose of today's visit _____

How long has it been since your last dental visit? _____

When were last x-rays taken? _____

Previous dentist's name _____

Address _____

How often do you brush? _____ Floss? _____

Have you ever had a night guard made? Yes No

Do your gums bleed when you brush or floss? Yes No

Are your teeth sensitive to hot, cold, or sweets? Yes No

Does food catch between your teeth? Yes No

Do you have sensitivity when biting? Yes No

Have you ever had periodontal (gum) treatment? Yes No

If yes, when? _____ Who did your treatment? _____

Have you ever had orthodontic treatment? Yes No

If yes, who did your treatment? _____

Is your home water supply fluoridated? Yes No

Are you currently experiencing any dental discomfort? Yes No

Do you have earaches or neck pain? Yes No

Do you have clicking, popping or discomfort in your jaw? Yes No

Do you grind your teeth? Yes No

Do you wear dentures or partials? Yes No

Are any of your teeth loose, or chipped? Yes No

How do you feel about your smile? _____

Medical History

Physicians Name _____ Clinic Location _____

Phone _____ Date of Last Medical Exam _____

Have there been any major health problems? (illness, surgery, hospitalization, etc.)

Give Dates _____

List any Medications you are currently taking _____

Do you or have you ever had any of the following diseases or problems?

Heart Condition	Yes No	Hepatitis, Liver Disease/Type ____	Yes No
Rheumatic Fever	Yes No	Aids or HIV/Infection	Yes No
High Blood Pressure	Yes No	Cancer	Yes No
Heart Murmur	Yes No	Chemotherapy	Yes No
Artificial Heart Valves	Yes No	Radiation Treatment of Head/Neck	Yes No
Pacemaker	Yes No	History of Alcoholism or Drug Abuse	Yes No
Mitral Valve Prolapse	Yes No	Artificial Joints	Yes No
Stroke	Yes No	If yes, when? _____	
Blood Disorder, Anemia	Yes No	Do you have allergies? (medications, metals, etc.)	Yes No
Abnormal Bleeding	Yes No	If yes, list _____	
Hemophilia	Yes No	Allergic to Latex	Yes No
Arthritis	Yes No	Do you smoke?	Yes No
Thyroid Problems: Hypo/Hyper	Yes No	How much? _____	
Fainting, Epilepsy, Blackouts	Yes No	Do you use chewing tobacco?	Yes No
Sinus Problems	Yes No	(Women Only) Are you:	
Asthma	Yes No	Pregnant?	Yes No
Kidney Problems	Yes No	Taking birth control pills?	Yes No

Signature of Party _____ **Dr. Sig** _____ **Date** ____/____/____