Date:_____

Patient Information

Name:_____ SS # _____
Last First Middle
Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____
Address:_____City:_____State:_____Zip:_____
Emergency Contact:_____ Relationship: _____Phone: ( )_____
Occupation: _____Height:_____ Weight :_____Date of Birth:_____ Sex: M _ F_

Whom may we thank for referring you to our practice? ☐Another patient, friend or relative (write name below) ☐ Dental or Doctors Office (write name below) ☐ Yellow Pages ☐Yellow Pages.com ☐Website ☐Other _____

Dental Information

	Yes	No	Don't Know
Have you ever had orthodontic (braces) treatment?	_	_	_
Do your gums bleed when you brush?	_	_	_
Are your teeth sensitive to hot, cold, sweets or pressure?	_	_	_
Do you have earaches or neck pain?	_	_	_
Have you had any periodontal (gum) treatment?	_	_	_
Do you wear removable dental appliances?	_	_	_
Have you ever had any complications following dental treatment?	_	_	_

If yes, please explain: _____

How would you describe your current dental problem?

Date of last dental visit:

Reason for visit:

Date of last x-rays:

How do you feel about the appearance of your teeth?

Medical Information

	Yes	No	Don't Know
If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.			
Have you had any of the following diseases or problems?			
Persistent cough greater than a 3 week duration	_	_	_
Active Tuberculosis	_	_	_
Cough that produces blood	_	_	_
Are you in good health?	_	_	_
Has there been any change in you general health within the past year?	_	_	_
Are you now under the care of a physician?	_	_	_
If yes what is/are the condition(s) being treated?			
Date of last physical examination?			
Physician:			
Name Phone			
Address City/State Zip			
Have you had any serious illness, operation or been hospitalized in the past 5 years?	_	_	_
If yes, what was the illness or problem?			
Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	_	_	_
If yes, what medicine(s) are you taking?			

	Yes	No	Don't Know
Vitamins, natural or herbal preparations and/or diet supplements:			
Prescribed:			
Over the counter:			
Are you taking, or have you taken, any diet drugs such as Pondimin(fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	_	_	_
Do you drink alcoholic beverages?	_	_	_
If yes, how much alcohol did you drink in the last 24 hours?			
In the past week?			
Are you alcohol and/or drug dependent?	_	_	_
If yes have you received treatment?	_	_	
Do you use drugs or other substances for recreational purposes?	_	_	
If yes, please list:			
Frequency of use: (daily, weekly, etc.):			
Number of years of recreational drug use:			
Do you wear contact lenses?	_	_	_
Do you use tobacco (smoking, snuff, chew)?	_	_	_
If yes, how interested are you in stopping? (circle one) Very / Somewhat / Not interested			

WOMEN ONLY

Nursing?	_	_	_
Taking birth control pills or hormonal replacement?	_	_	_

Are you allergic to or have you had a reaction to?	Yes	No	Don't Know
Local anesthetics	–	–	–
Aspirin	–	–	–
Penicillin or other antibiotics	–	–	–
Barbiturates, sedatives, or sleeping pills	–	–	–
Sulfa drugs	–	–	–
Codeine or other narcotics	–	–	–
Latex	–	–	–
Iodine	–	–	–
Hay fever/seasonal	–	–	–
Animals	–	–	–
Food (specify)_____	–	–	–
Other (specify)_____	–	–	–
Metals(specify)_____	–	–	–

To yes responses, specify type of reaction.

	Yes	No	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	–	–	–

If yes, when was this operation done?

If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint?

	Yes	No	Don't Know
	–	–	–

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

	Yes	No	Don't Know
	–	–	–

If yes, what antibiotic and dose?

Name of physician or dentist:

Phone:

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.	Yes	No	Don't Know
Abnormal bleeding	–	–	–
AIDS or HIV infection	–	–	–
Anemia	–	–	–
Arthritis	–	–	–
Rheumatoid arthritis	–	–	–
Asthma	–	–	–
Blood transfusion. If yes, date: _____	–	–	–
Cancer / Chemotherapy / Radiation Treatment	–	–	–
Cardiovascular disease. If yes, specify below:	–	–	–
___Angina ___ Heart murmur			
___Arteriosclerosis ___High blood pressure			
___Artificial hear valves ___Low blood pressure			
___Congenital heart defects ___Mitral valve prolapse			
___Congestive heart failure ___Pacemaker			
___Coronary artery disease ___Rheumatic heart disease/Rheumatic fever			
___Damaged heart valves ___Heart attack			
Chest pain upon exertion	–	–	–
Chronic pain	–	–	–
Disease, drug, or radiation-induced immunosuppression	–	–	–
Diabetes. If yes specify below:	–	–	–
___ Type I (Insulin Dependent) ___ Type II			
Dry Mouth	–	–	–
Eating disorder. If yes specify:_____	–	–	–
Epilepsy	–	–	–
Fainting spells or seizures	–	–	–
Gastrointestinal disease	–	–	–
G.E. Reflux / persistent heartburn	–	–	–
Glaucoma	–	–	–

	Yes	No	Don't Know
Hemophilia	–	–	–
Hepatitis, jaundice or liver disease	–	–	–
Recurrent Infections	–	–	–
If yes, indicate type of infection:			
Kidney problems	–	–	–
Mental health disorders,	–	–	–
If yes specify:			
Malnutrition	–	–	–
Night sweats	–	–	–
Neurological disorders,	–	–	–
If yes, specify:			
Osteoporosis	–	–	–
Persistent swollen glands in neck	–	–	–
Respiratory problems. If yes, specify below:	–	–	–
___Emphysema ___Bronchitis, etc.			
Severe headaches / migraines	–	–	–
Severe or rapid weight loss	–	–	–
Sexually transmitted disease	–	–	–
Sinus trouble	–	–	–
Sleep disorder	–	–	–
Sores or ulcers in the mouth	–	–	–
Stroke	–	–	–
Systemic lupus erythematosus	–	–	–
Tuberculosis	–	–	–
Thyroid problems	–	–	–
Ulcers	–	–	–
Excessive urination	–	–	–

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

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

SIGNATURE OF PATIENT/ GUARDIAN DATE

FOR COMPLETION BY DENTIST

Payment is due when services are rendere
Collection charges incurred are to be paid by patie

Heath History Update:

Date: Comments: Signature of patient and dentist: