Today's Date _____

PERSONAL INFORMATION

Name _____ **Your** Preferred Name _____ SSN _____
Address _____ Date of Birth _____
City _____ State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
Number you would like us to call to confirm appointments ☐ Home ☐ Work ☐ Cell
Email _____ Do you prefer email appointment confirmations? ☐ No ☐ Yes
Occupation _____ Place of Employment _____
Sex _____ Height _____ Weight _____ Marital Status _____ Spouse's Name _____
Referred By _____ Person Responsible for Account _____

Primary Dental Insurance
Insurance Company _____
Policy Holder ☐ Self ☐ Spouse ☐ Other
Policy Holder Name _____
Policy Holder SSN _____ Date of Birth _____

Secondary Dental Insurance
Insurance Company _____
Policy Holder ☐ Self ☐ Spouse ☐ Other
Policy Holder Name _____
Policy Holder SSN _____ Date of Birth _____

Physician Name _____ Phone _____
Name of General Dentist _____
Emergency Contact Information: Name _____ Phone _____

MEDICAL INFORMATION

Yes	No	
☐	☐	Are you currently taking any medications? (Please provide a list)
☐	☐	Do you take a low-dose aspirin every day?
☐	☐	Are you allergic to any medications? Please list _____
☐	☐	Do any medications cause nausea? Please list _____
☐	☐	Have you been seriously ill or hospitalized in the past 5 years?
☐	☐	Have you ever taken bisphosphonates (Fosamax, Boniva, Actonel, Zometa, etc. for osteoporosis)
☐	☐	Do you take pre-medication for a joint replacement or heart condition?

Yes	No	**(Women Only)**
☐	☐	Are you pregnant or nursing? (Circle one) Which trimester? _____
☐	☐	Are you or have you been through menopause?

Do NOT write in this box. Doctor's Use Only.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS?

Yes	No		Yes	No	
☐	☐	AIDS/HIV Positive	☐	☐	Chemotherapy
☐	☐	Allergies/Hay Fever	☐	☐	Chest Pains (Angina)
☐	☐	Anemia	☐	☐	Cholesterol
☐	☐	Arthritis/Rheumatism	☐	☐	Cortisone/Steroids
☐	☐	Asthma	☐	☐	Diabetes (Sugar Disease)
☐	☐	Bleeding Problems	☐	☐	Drug Addiction
☐	☐	Blood Transfusion	☐	☐	Drug Reactions
☐	☐	Cancer or Tumors	☐	☐	Epilepsy (Seizures)

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS?

Yes	No		Yes	No	
☐	☐	Headaches (frequent)	☐	☐	Psychological Problems
☐	☐	Head Injury	☐	☐	Radiation for Head/Neck Cancer
☐	☐	Heart Murmurs/Mitral Valve Prolapse	☐	☐	Rheumatic Fever/Heart Disease
☐	☐	Heart Attack: Date _____	☐	☐	Shortness of Breath
☐	☐	Hepatitis (Jaundice)	☐	☐	Sinus Trouble
☐	☐	High/Low Blood Pressure	☐	☐	Sleep Apnea
☐	☐	Joint Replacements	☐	☐	Stomach/Intestinal Disease (Ulcers)
☐	☐	Kidney Disease	☐	☐	Stroke: Date _____
☐	☐	Liver Disease	☐	☐	Thyroid Disease
☐	☐	Osteoporosis	☐	☐	Tuberculosis/Lung Disease
☐	☐	Prosthetic Hip or Heart Valves	☐	☐	Do you have any **OTHER** conditions we should know about? _____

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

Yes	No		Yes	No	
☐	☐	Antibiotics (Penicillin, etc.)	☐	☐	Herbal Medications
☐	☐	Anticoagulants (Blood Thinners)	☐	☐	High Blood Pressure Medication
☐	☐	Antihistamines (Benadryl, etc.)	☐	☐	Insulin (Diabetes Medication)
☐	☐	Aspirin (Advil, Aleve, etc.)	☐	☐	Nitroglycerin
☐	☐	Bisphosphonates (Fosamax, etc.)	☐	☐	Sulfa Drugs
☐	☐	Cortisone (Steroids)	☐	☐	Tranquilizers
☐	☐	Digitalis (Heart Medication)	☐	☐	**OTHER** _____

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO?

Yes	No		Yes	No	
☐	☐	Antibiotics (Penicillin, etc.)	☐	☐	Local Anesthetics
☐	☐	Barbiturates (Sedatives)	☐	☐	Narcotics (Codeine, etc)
☐	☐	Iodine	☐	☐	Sulfa Drugs
☐	☐	IV Sedation Medications	☐	☐	**OTHER** _____

DENTAL INFORMATION

Yes	No	**DO YOU:**	Yes	No	**HAVE YOU:**
☐	☐	Have dental pain now?	☐	☐	Had problems with local anesthetic?
☐	☐	Fear the dentist or dental treatment	☐	☐	Had prolonged bleeding with extractions?
☐	☐	Grind or clench your teeth?	☐	☐	Noticed shifting of your teeth?
☐	☐	Have TMJ pain?	☐	☐	Ever worn braces?
☐	☐	Have pain when opening/closing?	☐	☐	Ever been told you have gum disease?
☐	☐	Have an unpleasant taste?	☐	☐	Had problems with hot/cold sensitivity?
☐	☐	Brush at least twice per day?	_____		Date of most recent dental cleaning?
☐	☐	Floss at least once per day?			
☐	☐	Are you dissatisfied with the current condition or appearance of your teeth?			
☐	☐	Use tobacco products? Circle all that apply: Cigarettes Cigars Pipe Chewing Tobacco			

Patient's Signature _____ **Date** _____