

PATIENT INFORMATION

PURPOSE OF TODAY'S VISIT: _____ **TODAY'S DATE:** _____

Full Name: _____

Address: _____
(Street) (Apt. #) (City) (State) (Zip)

Phone: _____ Birthday: _____ M/F
(Home) (Work) (Cell)

Employer: _____ Position: _____ How Long: _____
(If self-employed, please list name of business/office address)

Marital Status: Married Single Divorced Separated Child

Social Security #: _____ Driver's License #: _____

Please let us know how you heard about our office: _____

In case of emergency, please notify: _____
(Name) (Phone)

Person Responsible for Account: _____

Insurance Company: _____
(Name) (Phone) (Employer)

Subscriber Name _____ DOB _____ SS/ ID # _____
(Please provide us with your card.)

Health Information

Are you in good health? _____ When was your last physical exam? _____

Physician's name/phone: _____

Have you had any serious illnesses/operations? _____ If so, please describe: _____

List medications and dosages : _____

Do you have any drug allergies? _____ Latex allergy ? : _____

If female, are you pregnant? _____ Nursing? _____

Have you ever had any of the following? Please check each one.

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble of any kind | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | High or low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma, sinus or hay fever | <input type="checkbox"/> | <input type="checkbox"/> | AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis or jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Nervous problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | Radiation treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or any or convulsive disorder | <input type="checkbox"/> | <input type="checkbox"/> | Excessive bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney or bladder problems | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Tumors, growths, cancers |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joints | | | |

Is there anything you would like us to know about your health? _____

DENTAL HEALTH INFORMATION

**Thank you for providing us with important information that will help us
to serve you better.**

Yes No

Have you experienced any of the following problems?

- | | | |
|---|--------------------------|--------------------------|
| Bleeding gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| Bad breathe? | <input type="checkbox"/> | <input type="checkbox"/> |
| Soreness in jaw joint? | <input type="checkbox"/> | <input type="checkbox"/> |
| Grinding or clenching of teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Snoring? | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic headaches, neck aches, shoulder pains? | <input type="checkbox"/> | <input type="checkbox"/> |
| Clenching or grinding your teeth, day or night? | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain or clicking in your jaw or ears? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you having any discomfort? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any sensitivity to hot, cold, sweets, chewing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does dental treatment make you nervous? | <input type="checkbox"/> | <input type="checkbox"/> |

On a scale of 1 to 10, with 10 being the
highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where would you like your dental health to be?
1 2 3 4 5 6 7 8 9 10

If I could improve my smile, I would make my teeth:

- | | | |
|--|--------------------------|--------------------------|
| Whiter? | <input type="checkbox"/> | <input type="checkbox"/> |
| Straighter? | <input type="checkbox"/> | <input type="checkbox"/> |
| Close spaces? | <input type="checkbox"/> | <input type="checkbox"/> |
| Replace black, mercury fillings with tooth colored restorations? | <input type="checkbox"/> | <input type="checkbox"/> |
| Repair chipped teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Replace missing teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Less gums showing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Replace old crowns or caps that don't match? | <input type="checkbox"/> | <input type="checkbox"/> |

Do you prefer to save your teeth?
1 2 3 4 5 6 7 8 9 10

Do you think your dental health affects your overall health?
1 2 3 4 5 6 7 8 9 10

Do you think it is important to have your teeth cleaned regularly?
1 2 3 4 5 6 7 8 9 10

- | | | |
|--|--------------------------|--------------------------|
| Do you smoke or use tobacco in any form? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink coffee or tea? | <input type="checkbox"/> | <input type="checkbox"/> |

Rate your diet's healthfulness:
1 2 3 4 5 6 7 8 9 10

How often do you brush? _____ Floss? _____ Fluoride? _____

When was your last dental visit? _____ Last oral cancer screening? _____

Reason for changing dentists? _____

Is there anything you would like us to know about your previous dental experience? _____

The above information is correct to the best of my knowledge. I authorize the dental team to perform the necessary dental services.

(Signature)

(Date)

Thank you for this information, it helps us to serve you better.