# Patient Information

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

Full Name: _____ Birthday: _____ M / F

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

Phone: _____ Email: _____
(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? _____ Are you under a physician's care now? _____ Last physical exam? _____

Physician's name/phone: _____ Have you ever had a serious head or neck injury?_____

Have you ever been hospitalized/major operation? _____ If so, please describe:_____

List medications and dosages:_____

Do you take, or have you taken, Phen-Fen or Redux? _____ Are you on a special diet? _____

Do you use tobacco? _____ Do you used controlled substances? _____

If female, are you pregnant/trying to get pregnant? _____ Nursing? _____ Taking oral contraceptives? _____

★**Are you allergic to: Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Other**_____★

Have you ever had any of the following? Please answer all questions.

| Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | AIDS/HIV Positive | | | Cortisone Medicine | | | Hemophilia | | | Renal Dialysis |
| | | Alzheimer's Disease | | | Diabetes | | | Hepatitis A | | | Rheumatic Fever |
| | | Anaphylaxis | | | Drug Addiction | | | Hepatitis B or C | | | Rheumatism |
| | | Anemia | | | Easily Winded | | | Herpes | | | Scarlet Fever |
| | | Angina | | | Emphysema | | | High blood pressure | | | Shingles |
| | | Arthritis/Gout | | | Epilepsy or Seizures | | | Hives or Rash | | | Sickle Cell Disease |
| | | Artificial Heart Valve | | | Excessive Bleeding | | | Hypoglycemia | | | Sinus Trouble |
| | | Artificial Joint | | | Excessive Thirst | | | Irregular Heartbeat | | | Spina Bifida |
| | | Asthma | | | Fainting Spells/Dizziness | | | Kidney Problems | | | Stomach/Intestinal |
| | | Blood Disease | | | Frequent Cough | | | Leukemia | | | Stroke |
| | | Blood Transfusion | | | Frequent Diarrhea | | | Liver Disease | | | Swelling of Limbs |
| | | Breathing Problem | | | Frequent Headaches | | | Low Blood Pressure | | | Thyroid Disease |
| | | Bruise Easily | | | Genital Herpes | | | Lung Disease | | | Tonsillitis |
| | | Cancer | | | Glaucoma | | | Mitral Valve Prolapse | | | Tuberculosis |
| | | Chemotherapy | | | Hay Fever | | | Pain in Jaw Joints | | | Tumors or growths |
| | | Chest Pains | | | Heart Attack/Failure | | | Parathyroid Disease | | | Ulcers |
| | | Cold Sores/Fever Blisters | | | Heart Murmur | | | Psychiatric Care | | | Venereal Disease |
| | | Congenital Heart Disorder | | | Heart Pacemaker | | | Radiation Treatments | | | Yellow Jaundice |
| | | Convulsions | | | Heart Trouble/Disease | | | Recent Weight Loss | | | |

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?
Bad breath?
Soreness in jaw joint?
Grinding or clenching of teeth?
Snoring?
Chronic headaches, neck aches, shoulder pains?
Clenching or grinding your teeth, day or night?
Pain or clicking in your jaw or ears?
Are you having any discomfort?
Any sensitivity to hot, cold, sweets, chewing?
Does dental treatment make you nervous?

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

Whiter?
Straighter?
Close spaces?
Replace black, mercury fillings with tooth colored restorations?
Repair chipped teeth?
Replace missing teeth?
Less gums showing?
Replace old crowns or caps that don't match?

Do you smoke or use tobacco in any form?
Do you drink coffee or tea?

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

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

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.

**Please fax back to our office at 512-346-4079**