The Traditional Art Of Caring

FAMILY, IMPLANT & COSMETIC DENTISTRY SINCE 1979

Please complete and sign the first page only

PLEASE PRINT Date_____

Name_____ Insurance Co._____

Name you would like us to call you_____ Policy#_____

Address_____ Name of Spouse/Parent_____

City_____ Zip_____ Spouse/Parent Date of Birth_____

Home Phone_____ Birthdate_____ Sex___ Spouse Occupation_____ Work Phone_____

Cell Phone_____ Email_____ Employed by_____

☐ Single ☐ Married ☐ Widowed ☐ Divorced Employer's address_____

Employed by_____ Your S.S. #_____

Employer's address_____ Your Driver's License #_____

Occupation_____ Work Phone_____ Children's Names & Ages_____

How did you hear about our office?_____

Emergency contact and phone #_____

PATIENT MEDICAL HISTORY

Physician:_____ Office Address_____

Office Phone_____ Approximate date of last physical examination_____

	Yes	No
1. Is your general health good?	☐	☐
2. Are you under a physician's care now?	☐	☐
3. Have you ever had trouble with bleeding after surgery?	☐	☐
4. Have you had any major operations? Or slow healing? If so, what?	☐	☐
5. Have you ever had a serious accident involving head injuries?	☐	☐
6. Have you had any allergic or adverse response to any medicines including Penicillin, aspirin, or latex?	☐	☐
7. Has a physician ever informed you that you had: A Heart Murmur or Mitral Valve Prolapse?	☐	☐
8. High Blood Pressure?	☐	☐
9. Pacemaker, Artificial Heart Valves?	☐	☐
10. Diabetes? Glaucoma?	☐	☐
11. Arthritis?	☐	☐
12. Tumors or Cancers?	☐	☐
13. Any Blood Disease, Anemia, Thyroid Problems?	☐	☐
14. Lung Problems, Asthma, Bronchitis?	☐	☐
15. Seizures? Epilepsy?	☐	☐
16. Do you snore?	☐	☐
17. Do you have daytime drowsiness?	☐	☐
18. Any Kidney Disease? Liver Disease?	☐	☐
19. Any Stomach or Intestinal Disease?	☐	☐
20. Any Venereal Disease?	☐	☐
21. AIDS?	☐	☐
22. Jaundice or Hepatitis?	☐	☐
23. Do you have night sweats accompanied by weight loss or cough?	☐	☐
24. Are you on a diet at this time?	☐	☐
25. Are you now taking drugs or medications?	☐	☐
26. Do you take Birth Control Pills?	☐	☐
27. Are you pregnant?	☐	☐
28. Do you have a history of fainting?	☐	☐
29. Have you ever had Radiation Therapy?	☐	☐
30. Do you have any prosthetic joints? (i.e., knee, hip, shoulders)	☐	☐
31. Have you ever taken any medication for Osteoporosis?	☐	☐
32. Is there any other information about your health which should be known?	☐	☐

PATIENT DENTAL HISTORY

	Yes	No
33. Do you have any dental complaints, pains, concerns?	☐	☐
34. Do you chew on only one side of your mouth? If so, why?	☐	☐
35. Do your gums bleed? Are they swollen?	☐	☐
36. Is any tooth sore to eating pressure, cold, or sweets?	☐	☐
37. When was your last full mouth x-ray series? Where?	☐	☐
38. Do you have any unhealed sores, swelling or growths in your mouth?	☐	☐
39. Do you clench or grind your teeth during the night or day?	☐	☐
40. Do you have pain near your ears?	☐	☐
41. Do you want to change your smile?	☐	☐
42. Are you unhappy with the appearance of your teeth?	☐	☐
43. Do you have discolored teeth or want to consider bleaching?	☐	☐
44. Do you wear dentures, plates, or partials? How old are they?	☐	☐
45. Do you have problems with your dentures staying in place?	☐	☐
46. Do you have trouble chewing the foods you want to eat?	☐	☐
47. Would you like instructions on proper brushing technique and gum care?	☐	☐
48. Are you nervous about dental work or injections?	☐	☐
49. Do you avoid regular dental care due to fear or anxiety?	☐	☐
50. Have you ever had an allergic reaction to Novocaine or local anesthetic?	☐	☐
51. Any difficult extractions in the past?	☐	☐
52. Any prolonged bleeding following extractions?	☐	☐

Medications List:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies List:

_____

_____

_____

_____

_____

Signature:_____