— FAMILY, IMPLANT & COSMETIC DENTISTRY —

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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____ 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 us?_____ _____

PATIENT MEDICAL HISTORY

Physician_____ Office Address_____
Office Phone_____ Date of last physical examination (approx.)_____

		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 ever had any major operations or slow healing? If so, what? _____	☐	☐
5.	Have you ever had a serious head injury?	☐	☐
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 or 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 currently?	☐	☐
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?	☐	☐
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, or 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 whitening?	☐	☐
44.	Do you wear dentures, plates or partials? If so, 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 and flossing technique?	☐	☐
48.	Are you nervous about dental work or injections?	☐	☐
49.	Do you avoid dental care due to fear or anxiety?	☐	☐
50.	Have you ever had an allergic reaction to Novocaine or local anesthetic?	☐	☐
51.	Any difficult extractions or prolonged bleeding following extractions in the past?	☐	☐

Medications List:

_____
_____
_____
_____
_____
_____
_____

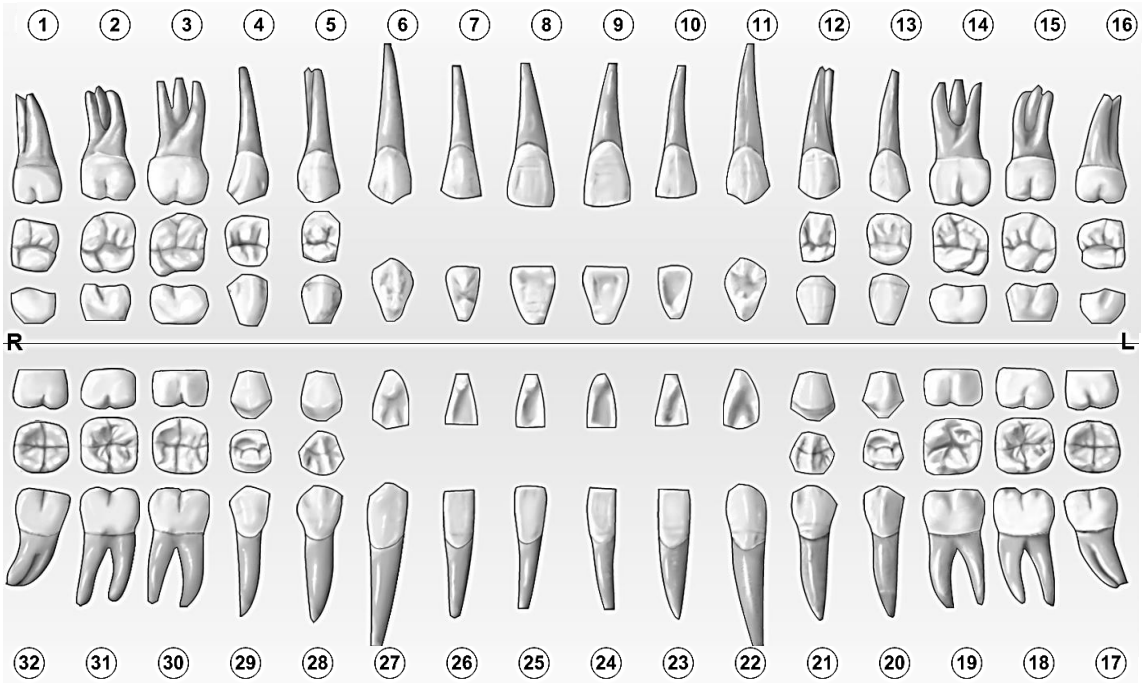
Allergies List:

_____
_____
_____
_____

Patient Signature _____

Patient Name_____ Date _____

[USE **BLACK** INK FOR EXISTING RESTORATIONS/CONDITIONS & **RED** INK FOR RESTORATIVE NEEDS]



Chief Dental Complaint:

_____

_____

_____

_____

Oral Habits:

_____

_____

_____

BP: ____/____ P:_____

Pre-Med Required: Y / N

PSR Score:

Oral Cancer Screening:

_____

IOE (Soft Tissue/Mallampati Class): _____

_____

_____

_____

TMJ- _____ **Lymph Nodes-** _____

EOE: _____

Ortho evaluation: _____

_____

X-Ray Findings: _____

_____

_____

Periodontal evaluation:

_____

_____

Treatment Recommendations: (NP / Periodic)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Doctor's Signature _____ Assistant's Initials _____