



WELCOME



We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____
 SS/HIC/Patient ID # _____
 Patient Name _____
 Address _____
 City _____
 State _____ Zip _____
 E-mail _____
 Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Occupation _____
 Patient Employer/School _____
 Employer/School Address _____
 Employer/School Phone (_____) _____
 Spouse's Name _____
 Birthdate _____ SS# _____
 Spouse's Employer _____
 Whom may we thank for referring you? _____

PHONE NUMBERS

Phone (_____) _____
 Cell (_____) _____
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)
 Name _____ Relationship _____
 Phone (_____) _____ Ext _____

DENTAL INSURANCE

Subscriber's Name _____
 Relationship to Patient _____
 Birthdate _____ SS# _____
 Insurance Co. _____
 Group # _____ Phone (_____) _____

- With in the last 3 years, have you been hospitalized or had surgery?** Yes No
 If Yes, please give reasons and dates: _____
- Have you ever been instructed to take ANY medications or take ANY special precautions before any dental appointments*?** Yes No
 If Yes, please explain: _____
- Are you taking ANY drugs, medications, or treatments at this time?** Yes No
 (If you brought a complete written list with you, give that to the receptionist instead)
 Prescribed: _____
 Over-the-counter (OTC) medications (such as Aspirin, Advil, allergy medication, sleep aids, or vitamins, etc): _____
- Are you taking any blood thinners or Aspirin?** _____ Yes No
- Are you taking or have you ever taken / been treated with a Bisphosphonate (Fosamax)** Yes No
- Are you allergic to or have you ever experienced an unusual reaction to:**
 Latex Metals or jewelry Dental anesthesia (local)
 Fluoride Nitrous oxide (laughing gas) General anesthesia None
- Are you allergic to or have you ever had any reaction to any of the following drugs?**
 Penicillin (or related drugs) Tranquilizers (Valium) Tetracycline Codeine
 Aspirin / Ibuprofen (Advil, Motrin, Nuprin) Keflex (Cephalexin) Sulfa drugs Iodine
 NSAIDS (Celebrex, Vioxx, Anaprox) Clindamycin (Cleocin) Erythromycin None
- Have you had an allergic reaction or unusual response to ANY other medication, drugs, pills, or treatments?** Yes No
 If Yes, please list: _____

Health Information and History (continued)

Hgt: _____ Wgt: _____

Primary Physician: _____ Phone: _____

Date of last physical examination: _____ Date of last blood test/work up: _____

Other Physicians and Specialists

Name: _____ Specialty: _____ Phone: _____ City & State: _____

Pharmacy _____ Phone _____

9. Do you have, or have you ever had, any of the following? (Please check Yes or No for each question)

	Yes	No		Yes	No
A compromised immune system (lupus, HIV, AIDS, radiation immune problems, etc.)	___	___	Hay fever, skin or food allergies or allergies in general	___	___
A sore or wound that bleeds easily or does not heal	___	___	Heart attack If Yes, date _____	___	___
A thyroid problem or disease	___	___	Heart disease	___	___
An active sexually transmitted disease (STD)	___	___	Heart surgery	___	___
Anemia	___	___	If Yes, type and date _____	___	___
Angina or chest pains	___	___	Heart valve(s) damage / Mitral valve prolapse	___	___
Any artificial joint, joint surgery, or prosthesis If yes, what joint or area? _____	___	___	Hemophilia or bleeding disorder	___	___
When was operation done? _____	___	___	Hepatitis type____, jaundice, or other liver problems	___	___
Any form of cancer	___	___	High blood pressure	___	___
Any kidney problems	___	___	Infective Endocarditis*	___	___
Any mental health issues	___	___	Low blood pressure	___	___
Any organ transplant	___	___	Pacemaker	___	___
Arthritis	___	___	Rheumatic heart disease / rheumatic fever	___	___
Artificial heart valve	___	___	Sinus problems	___	___
Asthma	___	___	Skin problems	___	___
Atherosclerosis	___	___	Stroke or CVA	___	___
Been treated for any psychiatric condition	___	___	Tuberculosis, emphysema or lung disorder	___	___
Congenital heart defects	___	___	Ulcers, acid reflux, or stomach problems	___	___
Congestive heart failure	___	___	Women Only:	Yes	No
Coronary artery disease	___	___	Are you pregnant?	___	___
Diabetes or blood sugar problems	___	___	If Yes, what is your due date? _____	___	___
Epilepsy or other seizure disorder	___	___	Do you think you might be pregnant?	___	___
Excessive bleeding from any cut or incident	___	___	Are you presently nursing?	___	___
Glaucoma or any eye diseases	___	___	Are you using birth control medication?	___	___
			Are you taking hormone replacement therapy?	___	___

10. Do you have any other condition, diseases, or medical problems, or is there ANY other information that you would like us to know about, or what we should be aware of?

Yes No

If Yes, please explain: _____

CONSENT – To the best of my knowledge, all the preceding information is correct and if there is ever any change in health or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice.

I understand there are no guarantees or warranties in health or dental care.

Signature _____ Date _____

(Parent or guardian, if patient is a minor)

Reviewed By: _____



Dental and Oral Health Information



Patient's Name: _____ Date: _____

Please describe any specific dental problem or discomfort you are having at this time: _____
How long has it been present? _____

If you have had any of the following dental care please list the dentists and approximate dates:

Periodontal (gum) treatment or surgery: _____

"Braces" or any type of orthodontic treatment: _____

Dental Implants: _____

Any other type of oral surgery: _____

Do you have/have you had/have you noticed any of the following signs or symptoms in your head, neck or mouth?

(Please check Yes or No for each question)	Yes	No		Yes	No
Teeth that are sensitive to:			A clicking, snapping or difficulty when chewing	___	___
Hot, cold, sweets, or biting pressure	___	___	Difficulty opening or moving the jaws	___	___
An unpleasant taste or persistent bad breath	___	___	Difficulty speaking or changes in your voice	___	___
Does food catch between your teeth	___	___	Difficulty moving your tongue or "tongue tied"	___	___
Do your gums bleed when brushing	___	___	Loose or separating teeth	___	___
Red, swollen, tender, bleeding, or sore gums	___	___	Changes in the way your teeth fit together	___	___
Gums that have pulled away from the teeth	___	___	A color change in the tissues in your mouth	___	___
Pus between the teeth and gums	___	___	Pain, tenderness, numbness, or earaches	___	___
Avoid any area when brushing or chewing	___	___	Any lumps, swelling or swollen glands	___	___
You clench or grind your teeth	___	___	Sores, ulcers or rough spots in your mouth	___	___

Your Dental Health:

How do you rate your overall dental health? _____ **Good Fair Poor**
How many times a day do you brush your teeth? _____ How many times a week do you floss your teeth? _____

Do you use any of the following? (Please check Yes or No for each question)	Yes	No
Mechanical (electric) toothbrush. If yes, what type or brand? _____	___	___
Flossing aids (floss holders, threaders, etc.) _____	___	___
Oral irrigating device (Waterpik) _____	___	___
Fluoride treatments or supplements at home. If Yes, which ones: _____	___	___
Mouthwashes or oral rinses. If Yes, what brand? _____	___	___

Do you have any missing teeth that have not been replaced? _____
Why have you not had them replaced? _____

Do you wear any removable dental appliances? _____
If Yes, what type and for how long? _____

Have you ever had your teeth whitened or bleached? _____
Would you like to have your teeth whitened or bleached? _____

How do you feel about the appearance of your smile and what would you change if you could? _____

Are you concerned about the finances required to return your mouth to excellent health? _____

Are you frustrated because you always need something treated or repaired when you visit a dentist? _____

Do you feel you will eventually wear artificial dentures? _____

Have you had any complications from an extraction or dental treatment? _____
If Yes, please explain: _____

Have you ever had any other dental conditions, major trauma or injury to your head, neck, or mouth? _____
If Yes, please specify: _____

If you are a new patient to this practice:
Date of last dental visit _____ Dentist's name _____ City and State _____

Reviewed By: _____

Oral Health Risk Factors

Patient's Name: _____

1. Do you smoke or have you **EVER** smoked? Yes No

(If No, proceed to question 2)

The amount that you are presently smoking (Check ALL that apply)

- None (quit smoking completely) Less than 1 pack of cigarettes per day An occasional cigar
 An occasional cigarette 1-2 Packs of cigarettes per day Cigars on a daily/regular basis
 A few cigarettes a day 2 or more packs of cigarettes per day Occasional pipe smoker
 A pipe on a daily/regular basis

If you have quit smoking, when did you quit?

- Less than 6 months ago 6 months to a year ago 1 to 3 years ago Over 3 years ago

How many years have you or did you smoke?

- Less than 2 years 2-5 years 5-10 years 10-20 years Over 20 years

2. Do you/have you **EVER** chew/chewed tobacco or use/used snuff or other similar substance? Yes No

(If No, proceed to question 3)

Are you **STILL** using smokeless tobacco or stuff?

If No, **WHEN** did you quit?

- Less than 6 months ago 6 months to a year ago 1 to 3 years ago Over 3 years ago

How many years did you use or have you used smokeless tobacco?

- Less than 1 years 1-2 years 2-5 years Over 5 years

3. Approximate average amount of alcoholic beverages presently consumed per week:

- None Less than 1 per week 1-5 drinks 6-11 drinks 11-20 drinks Over 20 drinks

4. Approximate average amount of soda/sugary drinks do you presently consume per week? _____

5. Do you have or have you ever had a substance abuse problem? Yes No

Describe _____

6. Do you presently use any recreational drug? Yes No

List _____

7. Do you have or have you ever had an eating disorder? Yes No

If Yes, Please Specify: _____

8. Do you have or have you ever had any head, neck or mouth piercing(s)? (Other than ears) Yes No

Describe _____

9. Do you have or have you ever been informed that you have been infected with an oncogenic strain (possible cancer-causing) of the Human Papilloma Virus (HPV)? Yes No

10. Please list your history or any family member's history of cancer:

11. Other concerns and considerations:

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