Thank you for choosing our office to assist you with your dental needs. Please fill out your information below.

**PERSONAL INFORMATION:**

Patient’s Name: Click or tap here to enter text. Date of Birth: Click or tap here to enter text.

Gender: Click or tap here to enter text. If minor, name of legal guardian: Click or tap here to enter text.

Home Phone: Click or tap here to enter text. Mobile/Cell Phone: Click or tap here to enter text.

Email Address: Click or tap here to enter text.

Mailing Address: Click or tap here to enter text.

Employer: Click or tap here to enter text.

Emergency Contact Name: Click or tap here to enter text.

Address: Click or tap here to enter text.

Phone #: Click or tap here to enter text. Relationship: Click or tap here to enter text.

Whom we may thank you for referring you to our office: Click or tap here to enter text.

**INSURANCE INFORMATION:**

Dental Insurance Company: Click or tap here to enter text.

Group/Policy/Pal #: Click or tap here to enter text. Certificate/Member ID: Click or tap here to enter text.

**2nd Insurance Information:**

Plan Member’s Name: Click or tap here to enter text. Date of Birth: Click or tap here to enter text.

Dental Insurance Company: Click or tap here to enter text.

Group/Policy/Pal #: Click or tap here to enter text. Certificate/Member ID: Click or tap here to enter text.

**MEDICAL AND DENTAL HEALTH HISTORY**

**MEDICAL HISTORY**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| Are you in good health? |[ ] [ ]
| When was the last time you had a medical examination? |[ ] [ ]
| Are you presently receiving treatment for any illness? |[ ] [ ]
| If yes, please provide details: Click or tap here to enter text. |  |  |
| Have you ever been hospitalized? |[ ] [ ]
| If yes, please provide details: Click or tap here to enter text. |  |  |
| Do you have any heart or circulatory problems? |[ ] [ ]
| Do you have a pacemaker? |[ ] [ ]
| Have you ever had a rheumatic fever? When? Click or tap here to enter text. |[ ] [ ]
| Have you ever been advised to take antibiotic pre-medication prior to dental treatment? |[ ] [ ]
| Do you have seasonal/hay fever allergies? |[ ] [ ]
| Do you have food allergies? |[ ] [ ]
| Do you have other allergies? |[ ] [ ]
| Are you taking any kind of medication?  |[ ] [ ]
| If yes, please specify the drug and reason: Click or tap here to enter text. |  |  |
| Have you ever had a reaction to any kind of medicine or dental local anesthethic? |[ ] [ ]
| Female patients: Are you pregnant or think you may be pregnant? |[ ] [ ]
| Female patients: Are you breastfeeding? |[ ] [ ]
| Do you smoke or vape? |[ ] [ ]
| If yes, how much per/day/week?Click or tap here to enter text. |  |  |
| Do you grind or clench your teeth? |[ ] [ ]
| **Please indicate below if you presently have or have ever had any of the following:** |
| HIV/AIDS |[ ] [ ]
| Alcohol or Chemical Dependency |[ ] [ ]
| Arthritis or Rheumatism |[ ] [ ]
| Artificial Joints or Valves |[ ] [ ]
| Blood Transfusion |[ ] [ ]
| Cancer / Radiotherapy / Chemotherapy |[ ] [ ]
| Diabetes |[ ] [ ]
| Eating Disorders |[ ] [ ]
| Epilepsy / Seizures |[ ] [ ]
| Fainting / Dizzy Spells |[ ] [ ]
| High / Low Blood Pressure |[ ] [ ]
| Hyper / Hypo Glycemia |[ ] [ ]
| Kidney Disease |[ ] [ ]
| Liver Disease |[ ] [ ]
| Lung Disease |[ ] [ ]
| Mental or Nervous Disorder |[ ] [ ]
| Stomach Ulcers |[ ] [ ]
| Stroke |[ ] [ ]
| Tuberculosis |[ ] [ ]
| Venereal / Communicable Disease |[ ] [ ]
| **Do you suffer from any of the following?** |
| Headaches? |[ ] [ ]
| Earaches? |[ ] [ ]
| Neck aches? |[ ] [ ]

**DENTAL HISTORY**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| Last dental visit and treatment provided at this time? |[ ] [ ]
| Frequency of dental visits? |[ ] [ ]
| Previous Dentist (Name): Click or tap here to enter text. |[ ] [ ]
| Previous Dentist (Location): Click or tap here to enter text. |  |  |
| Have you had a complete of dental films/ x-rays taken? |[ ] [ ]
| If yes, where? Click or tap here to enter text. |  |  |
| And when? Click or tap here to enter text. |  |  |
| Do your gums bleed while brushing and flossing? |[ ] [ ]
| Are your teeth sensitive to hot or cold? |[ ] [ ]
| Do you feel pain in any of your teeth? |[ ] [ ]
| Do you have any sore or lumps in or near your mouth? |[ ] [ ]
| Have you ever had any head, neck, or jaw injuries? |[ ] [ ]
| **Have you ever experienced any of the following problems in your jaw?** |
| Clicking? |[ ] [ ]
| Pain (joint, ear or side of face) |[ ] [ ]
| Difficulty in opening/closing |[ ] [ ]
| Difficulty in chewing |[ ] [ ]
| Do you have frequent headaches? |[ ] [ ]
| Do you clench or grind your teeth? |[ ] [ ]
| Do you bite your lips? |[ ] [ ]
| Have you noticed any loosening of your teeth? |[ ] [ ]
| Does food get caught between your teeth? |[ ] [ ]
| Have you had periodontal (gum) treatment? |[ ] [ ]
| Have you received oral hygiene instructions for the care of your teeth and gums? |[ ] [ ]
| Have you had difficult dental extractions in the past? |[ ] [ ]
| Have you had prolonged bleeding following extractions in the past? |[ ] [ ]
| Do you wear dentures or partials? |[ ] [ ]
| If yes, placement date? Click or tap here to enter text. |  |  |
| Do you have dental implants? |[ ] [ ]
| If yes, placement date? Click or tap here to enter text. |  |  |
| Have you had orthodontic treatment? |[ ] [ ]
| If yes, date of completion? Click or tap here to enter text. |  |  |
| Have you had treatment from a dental specialist? |[ ] [ ]
| If yes, what type? Click or tap here to enter text. |  |  |
| And when? Click or tap here to enter text. |  |  |

**Is there any additional information related to your health that has not been addressed above?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of primary medical physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**