

Welcome

*Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us.
We will be happy to help.*

PATIENT INFORMATION (Confidential)

Student ID # _____

Email Address _____

Date _____

Name: _____ Birth date: _____ Home Phone _____

Address: _____ City _____ State _____ Zip _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Patient's or Parents Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you under medical care now? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Are you allergic to or have had any reactions to the following? : | | |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?
If yes, please explain _____ | <input type="checkbox"/> | <input type="checkbox"/> | Local anesthesia (e.g. Novocain)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine?
If yes, what medications? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or any other Antibiotics... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever taken Phen-Fen? | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use tobacco?..... | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use controlled substances?.. | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you wearing contacts?..... | <input type="checkbox"/> | <input type="checkbox"/> | Iodine..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Any Metals (nickel, mercury, etc.).. | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Latex Rubber..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other (please list) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | _____ | | |
| | | | 9. Women Only: | | |
| | | | a Are you pregnant or think you may be pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | b Are you nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | c Are you taking oral contraceptives?. | <input type="checkbox"/> | <input type="checkbox"/> |

10. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure...	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker..	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded ...	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/		
Fainting/Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement..	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Implants.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice ...	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Prob..	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Trans. Dis..	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Pro..	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Other_____	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Name of Previous Dentist _____ Address _____

City _____ State _____ Zip _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold ?.....	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour?.....	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions		
5. Do you have any sores or lumps in or near	<input type="checkbox"/>	<input type="checkbox"/>	in the past?.....	<input type="checkbox"/>	<input type="checkbox"/>
your mouth?.....			12. Have you had any prolonged bleeding		
6. Have you had any head, neck or jaw injuries?....	<input type="checkbox"/>	<input type="checkbox"/>	following extractions?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following			13. Have you had any orthodontic treatment?.	<input type="checkbox"/>	<input type="checkbox"/>
problems in your jaw?			14. Do you wear dentures or partials.....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking.....	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene		
Pain (joint, ear, side of face.....	<input type="checkbox"/>	<input type="checkbox"/>	instructions regarding the care of your		
Difficulty in opening or closing.....	<input type="checkbox"/>	<input type="checkbox"/>	teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing.....	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile?.....	<input type="checkbox"/>	<input type="checkbox"/>

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or any dependents.

X _____
Signature of patient (or parent if a minor)

Doctor's Comments: _____
