

PATIENT INFORMATION

CONFIDENTIAL

DATE _____

PATIENT NAME

(PLEASE PRINT)

NAME _____ BIRTHDATE _____ HOME PHONE _____

FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY NOT LIVING WITH YOU _____

PHONE _____

DRIVER'S LICENSE # _____ SS # _____

PATIENT MEDICAL/DENTAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

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|---|------------------------------|-----------------------------|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. ARE YOU UNDER MEDICAL TREATMENT NOW? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | 7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING? | YES | NO | YES | NO | YES | NO |
| 2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| IF YES, WHAT MEDICATION(S) ARE YOU TAKING? | _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. DO YOU USE TOBACCO? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS? | <input type="checkbox"/> | <input type="checkbox"/> | 8. WOMEN ONLY: | | | | | YES | NO |
| 6. ARE YOU WEARING CONTACT LENSES? | <input type="checkbox"/> | <input type="checkbox"/> | A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | B) ARE YOU NURSING? | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | C) ARE YOU TAKING BIRTH CONTROL PILLS? | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> |

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|--|--------------------------|--------------------------|---|--------------------------|
| 9. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? | YES | NO | YES | NO |
| <input type="checkbox"/> <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> EASILY WINDED | <input type="checkbox"/> |
| <input type="checkbox"/> <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> STROKE | <input type="checkbox"/> |
| <input type="checkbox"/> <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> HAY FEVER / ALLERGIES | <input type="checkbox"/> |
| <input type="checkbox"/> <input type="checkbox"/> SWOLLEN ANKLES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> |
| <input type="checkbox"/> <input type="checkbox"/> FAINTING / SEIZURES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> RADIATION THERAPY | <input type="checkbox"/> |
| <input type="checkbox"/> <input type="checkbox"/> ASTHMA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> |
| <input type="checkbox"/> <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> RECENT WEIGHT LOSS | <input type="checkbox"/> |
| <input type="checkbox"/> <input type="checkbox"/> EPILEPSY / CONVULSIONS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> |
| <input type="checkbox"/> <input type="checkbox"/> LEUKEMIA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> |
| <input type="checkbox"/> <input type="checkbox"/> DIABETES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> RESPIRATORY PROBLEMS | <input type="checkbox"/> |
| <input type="checkbox"/> <input type="checkbox"/> KIDNEY DISEASES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> OTHER _____ | <input type="checkbox"/> |
| <input type="checkbox"/> <input type="checkbox"/> AIDS OR HIV INFECTION | <input type="checkbox"/> | <input type="checkbox"/> | | |
| <input type="checkbox"/> <input type="checkbox"/> THYROID PROBLEM | <input type="checkbox"/> | <input type="checkbox"/> | | |

COMMENTS

SIGNATURE OF DENTIST _____ DATE _____

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|---|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| 1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | 8. DO YOU HAVE FREQUENT HEADACHES? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? | <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 LIQUIDS/FOODS? | <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 IN THE PAST? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? | <input type="checkbox"/> | <input type="checkbox"/> | 12. HAVE YOU HAD ANY ORTHODONTIC WORK? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? | <input type="checkbox"/> | <input type="checkbox"/> | 13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW? | | | 14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? | <input type="checkbox"/> | <input type="checkbox"/> |
| A) CLICKING? | <input type="checkbox"/> | <input type="checkbox"/> | 15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? | <input type="checkbox"/> | <input type="checkbox"/> |
| B) PAIN (JOINT, EAR, SIDE OF FACE)? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| C) DIFFICULTY IN OPENING OR CLOSING? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| D) DIFFICULTY IN CHEWING? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

SIGNATURE

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.

X

PATIENT, PARENT OR GUARDIAN

DATE