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Please answer all questions on **all** pages, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

PATIENT'S NAME _____ Nickname _____

Male Female Social Security No. _____ Birthdate ____ / ____ / ____

Mailing Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Cell _____ Email _____ Married Single Partnered Other

Whom may we thank for referring you? _____

Full-Time Student? School name & location _____

Patient Occupation _____ Employer _____ Work Phone _____

Name of Spouse _____ Birthdate ____ / ____ / ____ Social Security No. _____

Spouse Occupation _____ Employer _____ Work Phone _____

PRIMARY DENTAL INSURANCE

SECONDARY DENTAL INSURANCE

Employee _____

Employee _____

Employer _____

Employer _____

Insurance Co. _____ Group # _____

Insurance Co. _____ Group # _____

Employee's S.S. No. _____

Employee's S.S. No. _____

Person responsible for payment: _____

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IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Home Ph. No. _____ Work Ph. No. _____

Relationship to Patient _____

DENTAL HISTORY

Chief dental concern: _____
 Are you nervous about having dental treatment? Yes No
 Have you ever had a bad dental experience? Yes No
 Have you ever been premedicated to reduce dental anxiety? Yes No
 Do you have difficulty/pain when opening? Yes No
 Do you grind/clinch your teeth at night/day? Yes No
 Does your jaw get stuck, locked or "go out"? Yes No
 Difficulty / pain when chewing, talking, or using your jaws/teeth? Yes No
 Do you hear noises in your jaw joints? Yes No
 Pain about the ears, temples, cheeks or jaw joint? Yes No
 Does your bite feel uncomfortable or unusual? Yes No
 Have you had a recent injury to your head / jaw? Yes No

Have you been treated for a jaw joint problem? Yes No
 Do your teeth ever feel loose? Yes No
 Does food catch in-between your teeth? Yes No
 How often do you brush? _____ Floss? _____ Yes No
 Any difficulty chewing your food? Yes No
 Have you ever had periodontal/gum disease? Yes No
 Do feel you have bad breath? Yes No
 Are your teeth sensitive to cold / heat / etc? Yes No
 Have you ever taken antibiotics before dental care? Yes No
 Do you have frequent Headaches? Yes No
 Have you had Orthodontic care (braces)? Yes No
 Do your gums bleed when you brush? Yes No
 Are you happy with the way your smile looks? Yes No
 If not, what would you change? _____

HEALTH HISTORY

Do you feel you are in good health? Yes No
 Are you having any pain or discomfort at this time? Yes No
 Do you smoke or use tobacco in any form? Yes No
 If yes, are you interested in support for smoking cessation? Yes No
 Have you been hospitalized in the past 2 years? Yes No
 Have you been under the care of a medical doctor during the past 2 years? Yes No
 If yes, for what condition? _____

Physician Name _____
 Address _____ Phone: _____
 Are you currently taking any medications /drugs? Yes No
 List Medications: _____

 Women: Are you pregnant? Yes No
 Please list any serious medical condition(s) that you have/had:

Please check "Yes or No" to the following conditions:

<p>Y N <input type="checkbox"/> Angina Pectoris <input type="checkbox"/> Heart Disease / Attack / Stroke <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Heart Failure <input type="checkbox"/> High / Low Blood Pressure <input type="checkbox"/> Congenital Heart Defect <input type="checkbox"/> Heart Murmur / Rheumatic Fever <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Heart Pacemaker <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Diabetes Type: _____</p>	<p>Y N <input type="checkbox"/> Blood Transfusion / Anemia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Bruise Easily/Prolonged Bleeding <input type="checkbox"/> Hemophilia <input type="checkbox"/> Liver Disease / Yellow Jaundice <input type="checkbox"/> Kidney Failure/Disfunction <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Ulcers <input type="checkbox"/> Glaucoma <input type="checkbox"/> Chemotherapy / Cancer <input type="checkbox"/> X-ray / Cobalt Treatment</p>	<p>Y N <input type="checkbox"/> Cosmetic Surgery <input type="checkbox"/> Emphysema / Asthma <input type="checkbox"/> Cough / Tuberculosis (TB) <input type="checkbox"/> MRSA <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis / Rheumatism <input type="checkbox"/> Cortisone Medicine <input type="checkbox"/> Venereal Disease <input type="checkbox"/> A.I.D.S. / H.I.V. <input type="checkbox"/> Hepatitis: A B C (circle one) <input type="checkbox"/> Frequent Headaches</p>	<p>Y N <input type="checkbox"/> Artificial Joints (Hip, Knee) <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Fever Blisters / Cold Sores <input type="checkbox"/> Fainting / Dizzy Spells <input type="checkbox"/> Epilepsy / Seizures <input type="checkbox"/> Hay Fever / Sinus Trouble <input type="checkbox"/> Allergies / Hives <input type="checkbox"/> Shingles <input type="checkbox"/> Nervousness <input type="checkbox"/> Psychiatric Treatment <input type="checkbox"/> Depression/Bipolar (circle one) <input type="checkbox"/> Drug / Alcohol Addiction</p>
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Are you allergic to or have you reacted adversely to the following?

Antibiotics Aspirin Metals / Jewelry
 Codeine Latex Local/Dental Anesthetic

Are you aware of being allergic to any other medications or substances? If yes, please list:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____ **Date** _____

Medical History Update

(For Office Use Only)

Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____