Confidential Patient Information *(Please Print Legibly)*

Patient's Name: _____ Address: _____

City: _____ State: ____ Zip: _____ E-Mail_____

Phone Home_____ Work_____ Cell_____

SSN:_____ DOB___/___/_____ Sex_____ Marital Status_____

HEALTH INFORMATION

Personal Physician name and address: _____
Have you been hospitalized within the past 2 years? Explain. _____
Are you currently being treated by a physician? Explain. _____
Are you currently taking any medicines or drugs? Please list. _____
Are you allergic to any drugs? Please list. _____
Are you allergic to any metals including jewelry? Please list. _____
Do you have an allergy to latex examination gloves? _____
Do you bleed excessively upon injury? _____
Are you pregnant? _____ Are you taking birth control pills? _____Do you Smoke? _____
Do you have any of the following conditions which require premedication? Please circle.

☐Heart Murmur ☐Prosthetic Joint ☐Mitral Valve Prolapse

CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD

☐A. AIDS/HIV	☐H. Hepatitis	☐O. Psychiatric Therapy
☐B. Arthritis	☐I. Heart Problem*	☐P. Rheumatic Fever
☐C. Asthma	☐J. Heart Murmur	☐Q. Sexually Transmitted Diseases
☐D. Cancer	☐K. High Blood Pressure	
☐E. Diabetes	☐L. Jaundice	☐R. Stroke
☐F. Epilepsy	☐M. Kidney Disease	☐S. Tuberculosis
☐G. Glaucoma	☐N. Low blood Pressure	☐T. Other Diseases*

*If you circled either I or T please explain. _____

Children: Is this the child's first visit? _____

Does the child complain of dental problems? _____

PLEASE FINISH THE BACK OF THIS SHEET

PLEASE DO NOT WRITE BELOW THIS LINE

Please review and update your answers to all questions, then sign and date below.

Signature: _____ Date: ___/___/___ Signature: _____ Date: ___/___/___

Signature: _____ Date: ___/___/___ Signature: _____ Date: ___/___/___

Signature: _____ Date: ___/___/___ Signature: _____ Date: ___/___/___

Who referred you to our office? _____

Dental History

What is the reason for this visit? _____

Are you aware of any specific dental problems? _____

When were your last full mouth X-rays? (15-20 films) _____

What is your opinion on the condition of your teeth? ☐ POOR ☐ NEUTRAL ☐ GOOD

How do you feel about the appearance of your teeth? ☐ POOR ☐ NEUTRAL ☐ GOOD

Please mark YES or NO for the following questions:

Are you interested in whitening (bleaching) your teeth?	☐ Yes	☐ No
Is there anything about your smile you would like to change?	☐ Yes	☐ No
Have you ever been treated for periodontal disease?	☐ Yes	☐ No
Do your gums bleed when you brush?	☐ Yes	☐ No
Do your gums bleed when you floss?	☐ Yes	☐ No
Do you smoke? How much?_____	☐ Yes	☐ No
Does dental treatment make you nervous?	☐ Yes	☐ No

PERSON TO BE CONTACTED IN CASE OF EMERGENCY

Name:

_____

Address:

_____

Phone: (Home) _____ (Work) _____ (Cell) _____

SIGNATURE: _____ **DATE:** _____