

WELCOME TO OUR OFFICE

Your Name _____

Date Of Birth _____ Marital Status _____ SSN _____ - _____ - _____ E-MAIL: _____

Address _____ City _____ ST _____ Zip _____

Home Phone _____ Work Phone _____ Cell/Other _____

Your Employer _____ Position _____ Years There _____

Name of Spouse _____ Spouse Employer _____ Years There _____

PERSON RESPONSIBLE FOR ACCOUNT _____ Referred By: _____

What is the purpose of your visit? _____

Are you having discomfort at this time? _____ Where? _____ How long? _____

When was your last dental visit? _____ What was done then? _____

Was a recommendation made at that time? _____

How often do you brush? _____ What other cleaning aids do you use? _____

When was your last cleaning? _____ Do your gums bleed? _____ When? _____

Are your teeth sensitive to: ___ Sweets ___ Hot ___ Cold ___ Pressure ___ Chewing ___ Brushing

How do you feel about your smile? ___ Great/Confident ___ Okay ___ Dislike ___ Embarrassed

Do you use tobacco products? ___ Type _____ Frequency/Amt _____

Do you have a fear of dentistry? ___ If so, please tell us why _____

YOUR MEDICAL HISTORY

It is imperative that we have a recent, full and valid medical history on our patients. Please check any appropriate medical problems. Of course, your response will be held in strict confidence.

- ___ Artificial joint replacement
- ___ Heart Murmur
- ___ Heart Problems/MVP
- ___ Liver Disease
- ___ AIDS
- ___ Alcoholism History
- ___ Anemia
- ___ Arthritis
- ___ Allergies to anesthetics
- ___ Bleeding problems/excessive
- ___ Blood Pressure (HIGH)
- ___ Blood pressure (LOW)
- ___ Circulatory problems

- ___ Cold Sores/Fever Blisters
- ___ Diabetes
- ___ Epilepsy
- ___ Glaucoma
- ___ Hemophilia
- ___ Hepatitis
- ___ Herpes
- ___ HIV Positive
- ___ Implants
- ___ Kidney Disease
- ___ Malignancies
- ___ Psychiatric care
- ___ Rheumatic Fever

- ___ Radiation Treatment
- ___ Sickle Cell Disease
- ___ Sinus problems
- ___ Stroke
- ___ Tuberculosis
- ___ Ulcer
- ___ Venereal Disease
- ___ Other _____

LIST ALL
MEDICATIONS BELOW:

WOMEN: Are you pregnant? _____
WOMEN: Taking birth control pills? _____
Some antibiotics can interfere with birth control pill effectiveness. Check with pharmacist when taking antibiotics.

___ Allergies _____

YOUR PHYSICIAN'S NAME: _____ PHONE # _____

Last Examination: _____ Please, describe any current medical treatment, impending treatment/operations or any other medical or dental information that may possibly affect your current dental condition or treatment.

YOUR SIGNATURE (IS REQUIRED)

DR. SIGNATURE

DATE