

**PATIENT'S HISTORY AND INFORMATION**  
(Please print clearly)

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last Mr - Mrs - Miss First Middle Initial

Res. Address \_\_\_\_\_ Res. Phone \_\_\_\_\_  
 Bus. Address \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Employed By \_\_\_\_\_ Occupation \_\_\_\_\_ Soc. Security No. \_\_\_\_\_

Name of Dental Insurance \_\_\_\_\_ Group No. \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Spouse's Res. Address \_\_\_\_\_ Sp. Res. Phone \_\_\_\_\_  
 Spouse's Bus. Address \_\_\_\_\_ Sp. Bus. Phone \_\_\_\_\_

Employed By \_\_\_\_\_ Occupation \_\_\_\_\_ Soc. Security No. \_\_\_\_\_

Name of Dental Insurance \_\_\_\_\_ Group No. \_\_\_\_\_

Child Name \_\_\_\_\_ DOB \_\_\_\_\_ Child Name \_\_\_\_\_ DOB \_\_\_\_\_  
 Child Name \_\_\_\_\_ DOB \_\_\_\_\_ Child Name \_\_\_\_\_ DOB \_\_\_\_\_

Referred By \_\_\_\_\_

**DENTAL HISTORY**

Chief Oral Complaint \_\_\_\_\_

Date of Last Dental Exam \_\_\_\_\_ Date of Last Full Mouth X-Ray \_\_\_\_\_ Where? \_\_\_\_\_

Do you have or do you use any of the following - Indicate yes or no with a (✓)

✓ Yes	✓ No		✓ Yes	✓ No		✓ Yes	✓ No	
<input type="checkbox"/>	<input type="checkbox"/>	A desire to keep your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Clenching or grinding	<input type="checkbox"/>	<input type="checkbox"/>	Instruction on care of teeth & gums
<input type="checkbox"/>	<input type="checkbox"/>	A desire to replace missing teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Pain around ear	<input type="checkbox"/>	<input type="checkbox"/>	Texture of toothbrush _____
<input type="checkbox"/>	<input type="checkbox"/>	Teeth sensitive to cold, heat, sweets, or pressure	<input type="checkbox"/>	<input type="checkbox"/>	Unfavorable dental experience	<input type="checkbox"/>	<input type="checkbox"/>	Frequency of brushing _____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums. How Long _____	<input type="checkbox"/>	<input type="checkbox"/>	Complications from extractions	<input type="checkbox"/>	<input type="checkbox"/>	Frequency of flossing _____
<input type="checkbox"/>	<input type="checkbox"/>	Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment	<input type="checkbox"/>	<input type="checkbox"/>	Water pik
<input type="checkbox"/>	<input type="checkbox"/>	Food impaction	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	Disclosing tablets
<input type="checkbox"/>	<input type="checkbox"/>	Swelling or sores in mouth	<input type="checkbox"/>	<input type="checkbox"/>	Oral habits, i.e., nail biting, thumb sucking, etc.	<input type="checkbox"/>	<input type="checkbox"/>	Fluoride supplements
<input type="checkbox"/>	<input type="checkbox"/>	Injury to mouth or teeth	<input type="checkbox"/>	<input type="checkbox"/>	Cigarettes, pipe, cigar smoking	<input type="checkbox"/>	<input type="checkbox"/>	Topical fluoride treatment

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Phone No. \_\_\_\_\_ Date Of Last Physical Exam \_\_\_\_\_

✓ Yes	✓ No		✓ Yes	✓ No		✓ Yes	✓ No	
<input type="checkbox"/>	<input type="checkbox"/>	Are you in good health	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems
<input type="checkbox"/>	<input type="checkbox"/>	Surgery - when?	<input type="checkbox"/>	<input type="checkbox"/>	Radiation (X-Ray) treatments	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Allergic to drugs	<input type="checkbox"/>	<input type="checkbox"/>	Neurological problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems
<input type="checkbox"/>	<input type="checkbox"/>	Allergic to anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	A.I.D.S.
<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver problems or hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer or colitis
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant? Due date _____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia or blood problems	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care/emotional problems			
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever			

Are you under medical care? \_\_\_\_\_ What medicines are you currently taking? \_\_\_\_\_

**APPOINTMENTS:** The time necessary for your dental treatment is reserved for you. Please give us 24 hours notice if you need to cancel an appointment, so that another patient may use that time.

**INSURANCE:** The fees for our professional services are charged to you, the patient. We will accept insurance benefits to pay part or all of these fees, with you being responsible for all unpaid charges.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent or guardian, if patient is a minor)