# Patient information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please don't hesitate to ask.

Patient name _____ Today's date _____

Social Security No. _____ Date of birth _____ Age _____ Sex _____
Driver's license No. _____ State _____

Home address _____

_____

Phone _____ Cell phone _____

Billing address *(if different from above)* _____

_____

Employer/occupation _____ Business phone _____
Spouse's name _____ Spouse's phone _____
Emergency phone *(other than spouse)* _____

Primary dental insurance _____ Group No. _____
Secondary dental insurance _____ Group No. _____
Subscriber's name _____
Subscriber's Social Security No. _____ Date of birth _____ Age _____ Sex _____

Name of your medical doctor _____
Date of last visit to medical doctor _____

Name of previous dentist _____
Date of last visit to dentist _____
Referred to us by _____

**Dental health history**

Are you apprehensive about dental treatment? ☐ Yes ☐ No
Have you had problems with previous dental treatment? ☐ Yes ☐ No
Do you gag easily? ☐ Yes ☐ No
Do you wear dentures? ☐ Yes ☐ No
Does food catch between your teeth? ☐ Yes ☐ No
Do you have difficulty chewing your food? ☐ Yes ☐ No
Do you chew on only one side of your mouth? ☐ Yes ☐ No
Do you avoid brushing any part of your mouth because of pain? ☐ Yes ☐ No
Do your gums bleed easily? ☐ Yes ☐ No
Do your gums bleed when you floss? ☐ Yes ☐ No
Do your gums feel swollen or tender? ☐ Yes ☐ No
Have you ever noticed slow-healing sores in or around your mouth? ☐ Yes ☐ No
Are your teeth sensitive? ☐ Yes ☐ No
Do you feel twinges of pain when your teeth come in contact with:
- Hot foods or liquids? ☐ Yes ☐ No
- Cold foods or liquids? ☐ Yes ☐ No
- Sour foods? ☐ Yes ☐ No
- Sweets? ☐ Yes ☐ No

Do you take fluoride supplements? ☐ Yes ☐ No
Are you dissatisfied with the appearance of your teeth? ☐ Yes ☐ No
Do you prefer to save your teeth? ☐ Yes ☐ No
Do you want complete dental care? ☐ Yes ☐ No
How often do you brush? _____
How often do you floss? _____
Does your jaw make noise so that it bothers you? ☐ Yes ☐ No
or others? ☐ Yes ☐ No
Do you clench or grind your jaws frequently? ☐ Yes ☐ No
Do your jaws ever feel tired? ☐ Yes ☐ No
Does your jaw get stuck so that you can't open freely? ☐ Yes ☐ No
Does it hurt when you chew or open wide to take a bite? ☐ Yes ☐ No
Do you have earaches or pain in front of the ears? ☐ Yes ☐ No
Do you have jaw symptoms or headaches upon awaking in the morning? ☐ Yes ☐ No
Does jaw pain or discomfort affect your appetite, sleep, daily routine or other activities? ☐ Yes ☐ No
Do you find jaw pain or discomfort extremely frustrating or depressing? ☐ Yes ☐ No
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? ☐ Yes ☐ No
Do you have a temporomandibular (jaw) disorder (TMD)? ☐ Yes ☐ No
Do you have pain in the face, cheeks, jaws, joints, throat, or temples? ☐ Yes ☐ No
Are you unable to open your mouth as far as you want? ☐ Yes ☐ No
Are you aware of an uncomfortable bite? ☐ Yes ☐ No
Have you had a blow to the jaw (trauma)? ☐ Yes ☐ No
Are you a habitual gum chewer or pipe smoker? ☐ Yes ☐ No

**Medical health history**

Do you have or have you had any of the following? (check all that apply)

- ☐ Heart problems
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Blood pressure problem
- ☐ Heart murmur
- ☐ Heart valve problem
- ☐ Taking heart medication
- ☐ Rheumatic fever
- ☐ Pacemaker
- ☐ Artificial heart valve
- ☐ Blood problems
- ☐ Easy bruising
- ☐ Frequent nosebleed/Abnormal bleeding
- ☐ Blood disease
- ☐ Anemia
- ☐ Ever require a blood transfusion?
- ☐ Allergy problems
- ☐ Hay fever
- ☐ Sinus problems
- ☐ Skin rashes
- ☐ Taking allergy medication
- ☐ Asthma
- ☐ Intestinal problems
- ☐ Ulcers
- ☐ Weight gain or loss
- ☐ Special diet
- ☐ Constipation/diarrhea
- ☐ Kidney or bladder problems
- ☐ Fainting spells, seizures or epilepsy
- ☐ Stroke(s)
- ☐ Frequent or severe headaches
- ☐ Thyroid problems
- ☐ Persistent cough or swollen glands
- ☐ Premedications required by physician
- ☐ Cancer/tumor
- ☐ Diabetes
- ☐ Urinate more than six times a day
- ☐ Thirsty or mouth is dry much of the time
- ☐ Family history of diabetes
- ☐ Tuberculosis or other respiratory disease
- ☐ Do you drink alcohol?
  - › If so, how much?_____
- ☐ Hepatitis, jaundice or liver trouble
- ☐ Herpes or other STD
- ☐ HIV positive/AIDS
- ☐ Glaucoma
- ☐ Do you wear contact lenses?
- ☐ Head injury
- ☐ Epilepsy or other neurologic disease
- ☐ History of alcohol or drug abuse

During the past 12 months, have you taken any of the following?

- ☐ Antibiotics or sulfa drugs
- ☐ Anticoagulants (e.g., Coumadin)
- ☐ High blood pressure medicine
- ☐ Tranquilizers
- ☐ Insulin, Orinase or similar drug
- ☐ Aspirin
- ☐ Digitalis or drugs for heart trouble
- ☐ Nitroglycerin
- ☐ Cortisone (steroids)
- ☐ Natural remedies
- ☐ Nonprescription drug/supplements
- ☐ Other _____

Are you allergic, or have you reacted adversely, to any of the following?

- ☐ Local anesthetics (“Novocain”)
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives or sleeping pills
- ☐ Aspirin, acetaminophen or ibuprofen
- ☐ Codeine, Demerol or other narcotics
- ☐ Metals
- ☐ Latex or rubber dam
- ☐ Other _____

**Women**

- ☐ Are you taking contraceptives or other hormones?
- ☐ Are you pregnant?
- ☐ If so, expected delivery date _____
- ☐ Are you nursing?
- ☐ Have you reached menopause?
- ☐ If so, do you have any symptoms?

_____ Date _____

*Patient signature/legally authorized representative*

_____ Relationship _____

*Printed name if signed on behalf of the patient*

_____ Date _____

*Dentist signature*