

Date _____

Name _____ Spouse's Name _____

Home Address _____

Business Name & Address _____

Occupation _____ Social Security No. _____ - _____ - _____ Single _____ Married _____

Home Phone _____ Business Phone _____ Cell Ph. _____

Date of Birth _____ Age _____ Sex _____ Height _____ Weight _____

Email address (not required) _____

Contact person in case of emergency _____ Their Phone _____

Whom may we thank for referring you to us? _____

MEDICAL HEALTH

Name, address, and phone of physician _____

Have you been under a physician's care during the past 2 years? _____ For _____

Have you been treated in a hospital in the past 2 years? _____ For _____

List any major surgeries you have had: _____

If female: Are you taking hormones or birth control? _____ Are you pregnant or nursing? _____

Have you had canker sores or cold sores on your lips, tongue, gums or body? _____

Are you now taking daily medication? _____ If yes, please list all prescription and non-prescription medication:

Are you allergic to: Penicillin Codeine Latex Local anesthetics Other _____

Do you smoke or use smokeless tobacco products? _____ How much/frequent? _____

Have you had or do you now have:	yes	no		yes	no
Abnormal blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged cough	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart lesions	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Drug dependency	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>

Have you any disease, condition, or problem not previously listed? _____

DENTAL HEALTH

When was your last dental visit? _____

How often did you see your dentist? _____

Are you having any dental problems that require immediate attention? _____

Do any of the following cause tooth discomfort? Hot _____ Cold _____ Sweets _____ Chewing _____

How often do you brush your teeth? _____ Floss? _____ Water Jet? _____

Do your gums bleed while brushing? _____

Do your gums ever feel tender or swollen? _____

Have you had periodontal treatment? _____ When? _____

Do you clench or grind your teeth? _____

Do your jaws ever feel tired or ache? _____ Click or pop? _____

Can you chew on both sides of your mouth? _____ Comfortably? _____

Do you have frequent headaches? _____ Earaches? _____

Have you ever had orthodontic treatment (braces)? _____ When? _____

Do you lose fillings or break fillings? _____

Do you usually have many cavities? _____

Do you have any loose teeth? _____ Cracked or broken teeth? _____

Do you have any noticeable wear on your teeth? _____ Food traps _____

Do you have any missing teeth? _____ Have they been replaced? _____

If so, how? Fixed bridge _____ Removable partial _____ Full denture _____ Dental implant _____

Are you comfortable with the replacement? _____ Please describe _____

How do you feel about the appearance of your smile? _____

Have you ever had any cosmetic dentistry done to improve your appearance? _____

If yes, are you pleased with the result? _____ Please comment _____

Have you ever had an unpleasant dental experience? _____

Please add anything you feel is important: _____

Signature _____