# WELCOME TO OUR DENTAL OFFICE

Please Circle: Mr. Mrs. Miss Ms. Dr. Adult Child Male Female

Name: _____ Prefer to be Called: _____

Address: _____

Home Phone: (____) _____-_____ Work Phone: (____) _____-_____X_____

Mobile Phone: (____) _____-_____

Date of Birth: (D)_____/(M)_____/(Y)_____

Employer/School: _____Occupation: _____

Email: _____

Who may we thank for referring you to this office?: _____

Family Physician: _____ Phone: (____) _____-_____

In Case of Emergency Notify: _____Relation: _____ Phone: (____) _____-_____

Person responsible for this account (Please Circle): Self Spouse Parent Legal Guardian Other

(If not Self) Name: _____ Relation: _____

Address: _____

Home Phone: (____) _____-_____ Work Phone: (____) _____-_____X_____

## Primary Insurance

Subscriber: _____

Relation (Please Circle):Self Spouse Other

Insurance Co: _____

Policy/Plan #: _____ Division #: _____

Subscriber ID: _____ SIN: _____

Are You Familiar with Your Plan Details? Yes No

## Secondary Insurance

Subscriber: _____

Relation (Please Circle):Self Spouse Other

Insurance Co: _____

Policy/Plan #: _____ Division #: _____

Subscriber ID: _____ SIN: _____

Are You Familiar with Your Plan Details? Yes No

# MEDICAL HISTORY

ALL INFORMATION IS CONFIDENTIAL

The following information is required by your dentist to assist in proper diagnosis and treatment.

1. Have you ever had a serious illness requiring hospitalization or extensive medical care? ..... Yes No
   Please specify: _____
2. Are you presently under the care of a medical doctor? ..... Yes No
   If so, please explain: _____
3. Have you had a medical examination in the last year? ..... Yes No
4. Do you use any prescription or non-prescription drugs regularly? ..... Yes No
   Please specify: _____
   _____
5. Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex? ..... Yes No
6. Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea? ..... Yes No
   Please specify: _____
7. Have you been hospitalized in the last 5 years? ..... Yes No
   Please specify: _____
8. Have you ever experienced any unusual reaction to any of the following? (Please Circle) ..... Yes No
   Local anesthesia, codeine, aspirin, penicillin, erythromycin, tetracycline, sulpha drugs,
   barbituates (sleeping pills), or any other medicine? If so, please explain _____
   _____
9. Have you been warned against taking any drug or medication? ..... Yes No
10. Do you bruise easily or bleed abnormally? ..... Yes No
11. Have you ever had any organ implants or medical implants? ..... Yes No
12. Have you ever fainted? ..... Yes No
13. Do your ankles swell? ..... Yes No

14. Do you experience shortness of breath or chest pain when walking or climbing stairs? ..... Yes No
15. Do you have frequent headaches? ..... Yes No
16. Do you have A.I.D.S. or have you ever tested positive for H.I.V.? ..... Yes No
17. Do you have Hepatitis A, B, or C? ..... Yes No
18. Do you have any of the following? Please circle below any that apply ..... Yes No

| | | | |
|---|---|---|---|
| Heart Murmur/Mitral Valve Prolapse | Malignant Hyperthermia | Liver Disease | Herpes |
| Stomach/Intestinal Problems/Ulcers | Drug/Alcohol Dependency | Heart Attack | Sinus Trouble |
| Joint Replacement (hip, knees, etc.) | Venereal Disease | Cold/Canker Sores | Stroke |
| Mental or Nervous Disorder | Lung Disease (i.e. Asthma) | Jaundice | Kidney Problems |
| High/Low Blood Pressure | Thyroid Disease (high/low) | Diabetes (I or II) | Emphysema |
| Hyper(high)/Hypo(low) Glycemia | Arthritis or Rheumatism | Tuberculosis | Glaucoma |
| Epilepsy or Seizures | Scarlet or Rheumatic Fever | Other: _____ | |
| Cortisone/Steroid Therapy | Cancer/Chemotherapy | Other: _____ | |

19. Have you had any injury, surgery or x-ray therapy to your face or jaws? ..... Yes No
20. Do you have any disease, condition, or problem that you think your doctor should know about? ..... Yes No
21. WOMEN ONLY - Are you pregnant or suspect you might be? If so, what month are you in?_____
    Are you taking birth control pills? ..... Yes No
    Are you nursing? ..... Yes No

## DENTAL HISTORY

1. Reason for today's visit: (Please Circle) Exam Cleaning Emergency Other
   If Emergency or Other, please specify _____
   Are you presently having dental pain? ..... Yes No
   Is there a dental problem you would like to take care of as soon as possible? ..... Yes No
   Please specify: _____
2. How frequently do you see your dentist? (Please Circle) 6mths 9 mths Yearly Other: _____
   Former Dentist: _____ Last dental visit: _____
   Last Cleaning: _____ Last full mouth series of X-rays: _____
3. How often do your brush your teeth? _____Floss/How Often? _____
4. Do your gums bleed easily? ..... Yes No
5. Are your teeth sensitive to: Hot Cold Biting Sweets? ..... Yes No
6. Do you feel you have bad breath at times? ..... Yes No
7. Have you ever had jaw joint surgery? ..... Yes No
8. Do you have pain in your jaw joints or suffer from migraine headaches? ..... Yes No
9. Does any part of your mouth hurt when clenched? ..... Yes No
10. Does your jaw crack or pop when you open wide? ..... Yes No
11. Have you had: Braces Oral Surgery Gum Treatment Root Canal ..... Yes No
12. Do you grind or clench your teeth during the day or night? ..... Yes No
13. Do you smoke? Number per day: _____ ..... Yes No
14. Have you ever experienced any growths or sore spots in your mouth? If so, where? _____ Yes No
15. Previous problems with dental treatment? Please specify: _____ Yes No
16. Are you satisfied with the appearance of your teeth? ..... Yes No
17. Other Dental Concerns: _____
    _____

Office policy: Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 24 hours notice, otherwise it may be necessary to charge for time lost.

Patient Release: I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that responsibility for payment for the dental services provided for myself and my dependents is mine, and I will assume responsibility for fees associated with these services.

| | | |
|---|---|---|
| | | |
| Signature:Patient Parent Guardian | Date(mmm/dd/yy) | Reviewing Dentist |