PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____ Gender: M F Marital Status: S M

Date of birth: Month_____ Date: _____Year: _____ Age: _____ Insurance: ___Yes ___No

Home Address: _____City: _____State: _____ Zip: _____

Home Phone: (_____) _____Cell Phone: (_____)_____Email:_____

Soc. Sec. #: _____ Emergency Contact: Name:_____ Phone: _____

Patient under guardianship/conservatorship: Person responsible: _____Phone: _____

Do you have a "Durable Power of Attorney" for medical decisions? Yes No Name: _____Phone_____

Employed: _____ Address/city: _____

Work Phone: (_____) _____ Does your employer offer insurance?_____

No. of people in family: _____ Family Income: Wages: $_____ Unemployment: $_____Social Sec.: $_____

Public Assistance: $_____ other: $_____ Medicaid $_____Total: $ _____

DENTAL HISTORY

	YES	NO
Do your gums bleed when you brush?		
Have you noticed any lumps or sores in your mouth?	YES	NO
Are your teeth sensitive to cold, hot, sweets or pressure?	YES	NO
Have you ever injured your face, jaws or teeth?	YES	NO
Are you happy with the appearance of you teeth?	YES	NO
Are you allergic to any metals or dental materials?	YES	NO
What types of dental treatment you have had?	YES	NO

Have you had problems with previous dental treatment? YES NO

If yes explain:

_____

_____

_____

Do you have regular dental exams? YES NO

Orthodontics (braces) Denture Root Canal Implants

Oral Surgery Periodontal treatment TMJ (Jaw) Treatment Fillings

Date Last Dental Exam: _____ Date Last X-rays: _____

A detailed health history is invaluable for helping us treat you safely and effectively.
Please be very accurate in the following sections. The confidentiality of this medical record is assured.

Are you in good general health? ❑ Yes ❑ No List any illness or disease that you have been treated for in the last two years: _____.

List any prescription medications: _____

List any over-the-counter, natural or homeopathic medications: _____

List any known allergies: _____ List any recreational drugs used: _____

Doctor's name &

phone_____

Are you allergic to latex?. …… ❑ Yes ❑ No

Have you ever had heart problems?..…… ❑ Yes ❑ No

Have you ever had a heart attack? …… ❑ Yes ❑ No

Have you ever been told that you have a heart murmur? … ❑ Yes ❑ No

Do you have an artificial heart valve? …… ❑ Yes ❑ No

Have you had a heart infection? …… ❑ Yes ❑ No

Have you ever been told that you have a heart defect or congenital heart problems? …… ❑ Yes ❑ No

Do you get chest pain or angina? …… ❑ Yes ❑ No

Do you have jaw joint problems or a history of TMJ? …… ❑ Yes ❑ No

Do your ankles swell? …… ❑ Yes ❑ No

Women: Are you pregnant or nursing? …… ❑ Yes ❑ No

Do you have difficulty breathing or shortness of breath? …… ❑ Yes ❑ No

Have you ever had asthma attacks? …… ❑ Yes ❑ No

Do you have a cough? …… ❑ Yes ❑ No

Do you drink alcoholic beverages? …… ❑ Yes ❑ No

How much do you smoke?.....❑ None ❑ 1 pack/day ❑ 2 packs/day ❑ More

Have you ever had hepatitis? …… ❑ Yes ❑ No

Do you have HIV/AIDS, or have you been exposed to AIDS? ❑ Yes ❑ No

Do you have problems with ulcers? …… ❑ Yes ❑ No

Do you have digestive problems……... ... ❑ Yes ❑ No

Do you have difficulty urinating? …… ❑ Yes ❑ No

Do you urinate more than six times each day? …… ❑ Yes ❑ No

Are you diabetic? …… ❑ Yes ❑ No

Have you ever had seizures or convulsions?...…… ❑ Yes ❑ No

Have you ever had a stroke? …… ❑ Yes ❑ No

Do you get cold sores…… ❑ Yes ❑ No

Do you have any bleeding problems? …… ❑ Yes ❑ No

Have you been anemic recently? ……..…… ❑ Yes ❑ No

Have you ever had cancer or radiation therapy? …… ❑ Yes ❑ No

Do you have prosthetic or artificial joints? …… ❑ Yes ❑ No

Have you in the past taken, or are you currently taking any medication for osteoporosis? … …… ❑ Yes ❑ No

THIS INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE:

Signature of Patient, Parent if minor, Custodial Parent, or Legal Guardian Date