All information given on this form is for our records only and will be considered confidential. Date _____

1. Patient's Name _____ Birthdate _____ Spouses's first name _____
2. Address _____ City _____ State _____ Zip _____ Tel. No. _____
3. Employer _____ Occupation _____ Bus. Tel. No. _____
4. Spouse's Employer _____ Bus. Tel. No. _____ Email _____
5. Dental Ins.? Yes___ No___ Ins. Co. _____ Policy# _____ Group# _____
6. Social Security # _____ Spouse's Social Security# _____
7. If person other than you or your spouse is responsible for your finances, please give name and address _____
8. If patient is a minor, please fill in the name of parent or guardian _____
   Also complete 3-5 above with parent/guardian, employer information, etc.
9. Whom may we thank for referring you? _____ City _____
10. Regular Dentist _____ City _____

    Physician _____ City _____

PATIENT MEDICAL HISTORY

Have you ever had:	(✓) Yes	No
Heart Trouble		
Heart Murmur		
Rheumatic Fever		
High Blood Pressure		
Shortness of Breath		
Chest Pains		
Drug Reaction		
Allergies:aspirin, penicillin, codeine		
Allergy to Dental Anesthetics		
Allergy to Latex		
Diabetes		
Epilepsy		
Tuberculosis		
Glaucoma		
Thyroid or Parathyroid Disorder		
Ulcers or Stomach Trouble		
Cancer		
Radiation or Chemotherapy		
Hospitalization		
Joint Replacement Surgery		
Kidney Disease		
Liver Disease		
Hepatitis		
If yes, are you a hepatitis carrier?		
AIDS; ARC; or positive testing to HIV/HTLV$_3$		

Are you:	(✓) Yes	No
Presently under the care of a physician?		
Taking any medication now? or within past year?		
Date of last physical exam		
Aware of recent weight change?		
Subject to frequent urination?		
Often thirsty?		
Often exhausted or fatigued?		
Experiencing nighttime sweating?		
Subject to frequent headaches?		
Excessively nervous?		
In good health now?		
Do you smoke? How much?		
Does anyone in your family have diabetes?		
Do you have prolonged bleeding after injury or tooth extraction?		
If female, are you now:		
Pregnant?		
Taking anti-pregnancy drug?		
Presently in menopause?		
Post menopausal?		

Allergies _____

DENTAL HISTORY

Date of last dental visit.....
How often do you have a professional cleaning?.....
How often do you brush?.....
Do you use a hard, medium, or soft toothbrush?.....

	(✓) Yes	No
Do you use floss?		
Have you ever had trench mouth or pyorrhea?		
Have you had treatment for Periodontal Disease previously?		
Have you had Orthodontic Treatment (braces)?		
Do you have:		
Bleeding Gums		
Loose or shifting teeth		
Changing space between teeth		
Receding gums		
Sensitive teeth		
Halitosis (bad breath)		
Habit of clenching or grinding teeth		

Blood Pressure _____

List any current illnesses _____

List any current Medications _____

Briefly describe your main dental problem (chief complaint) _____

This form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE"

Patient / Parent or Guardian Signature: _____ **Date:** _____