



Patient Name: _____ Date: _____
Last _____ First _____ MI _____

Gender: _____ Marital Status: _____ Date of Birth: _____ Social Security #: _____

Phone: (home) _____ (work) _____ ext. _____ (cell) _____

E-Mail Address: _____

How would you like your appointment confirmed? Email Cell Phone Work Phone Home Phone

Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Dental History

Date of last dental visit: _____

(Please Circle) YES / NO Have you ever been told you need to pre-med or take antibiotics before a dental visit?

YES / NO Have you ever had a heart valve replacement or heart infection (endocarditis)?

YES / NO Are your teeth sensitive to hot or cold?

YES / NO Are your teeth sensitive to sweets or sour?

YES / NO Do you feel pain in any of your teeth?

YES / NO Do you have any sores or lumps in your mouth?

YES / NO Have you had any neck, head or jaw injuries?

YES / NO Do you have frequent headaches?

YES / NO Do you clench or grind your teeth?

YES / NO Do you bite your lips or cheeks frequently?

YES / NO Have you ever considered orthodontics?

YES / NO Have you ever had any orthodontic work done?

Have you ever experienced any of the following in your jaw? (Please Circle)

YES / NO Clicking / Popping

YES / NO Pain (Joint, Ear, Face)

YES / NO Difficulty opening / closing

YES / NO Difficulty Chewing

On a scale of 1-10, (1= Unhappy 10=Happy), how would you rate these:

Are you happy with your smile? 1 2 3 4 5 6 7 8 9 10

Do you feel your teeth are white enough? 1 2 3 4 5 6 7 8 9 10

How important are your teeth to you? 1 2 3 4 5 6 7 8 9 10

What would you change about your smile? _____

Is there anything else about having dental treatment you would like us to know? _____

Medical History

Are you under the care of a physician? YES / NO

Physician Name: _____ Office Phone: _____

Date of last physical exam: _____

Please list ALL Prescription and non Prescription Medications you are currently taking: _____

Allergies / Sensitivities (please Circle)

YES / NO Penicillin / Other Antibiotics
YES / NO Latex
YES / NO Sulfa Drugs
YES / NO Iodine
YES / NO Sedatives, Barbiturates, Sleeping Pills
YES / NO Aspirin
YES / NO Codeine / Other Narcotics
YES / NO Any Metals
YES / NO Other (please list) _____

Do you have, or have you had, any of the following? (please Circle)

YES / NO	AIDS/HIV Positive	YES / NO	Heart Murmur
YES / NO	Anemia	YES / NO	Heart Pacemaker
YES / NO	Angina	YES / NO	Heart Trouble/Disease
YES / NO	Arthritis/Gout	YES / NO	Hepatitis
YES / NO	Artificial Heart Valve	YES / NO	High or Low Blood Pressure
YES / NO	Artificial Joints	YES / NO	Hypoglycemia
YES / NO	Asthma	YES / NO	Intestinal Disease/Ulcers
YES / NO	Blood Disease	YES / NO	Kidney Problems
YES / NO	Cancer	YES / NO	Liver Disease
YES / NO	Chemotherapy/Radiation Treatment	YES / NO	Lung Disease
YES / NO	Chest Pains	YES / NO	Mitral Valve Prolapse
YES / NO	Congenital Heart Disorder	YES / NO	Rheumatic Fever
YES / NO	Diabetes	YES / NO	Rheumatism
YES / NO	Drug Addiction	YES / NO	Sexually Transmitted Disease
YES / NO	Emphysema	YES / NO	Stroke
YES / NO	Epilepsy or Seizures	YES / NO	Swelling of Limbs
YES / NO	Fainting Spells/Dizziness	YES / NO	Thyroid Disease
YES / NO	Glaucoma	YES / NO	Tuberculosis
YES / NO	Hay Fever	YES / NO	Tumors or Growths
YES / NO	Heart Attack/Failure		

All (please Circle)

YES / NO Do you smoke or use any tobacco products?

Women (please Circle)

YES / NO Do you take Bisphosphonate Meds (Fosomax, Actonal, Didracal,etc.) YES / NO Are you pregnant?
YES / NO Do you take Birth Control Pills / Hormone Therapy Pills? YES / NO Are You nursing?

To the best of my knowledge all of the preceding answers and information provided are true and correct.

Date: _____ Relationship to Patient: _____