SPECIALIZING IN IMPLANT, AESTHETIC AND RESTORATIVE DENTISTRY

PATIENT INFORMATION

Patient Name: ______________________ Date: __________
Last, First MI (Preferred Name)

Gender: M ☐ F ☐ Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐

Birth Date: __________ Soc. Sec.: __________ Drivers License: __________

Home Phone: __________ Work Phone: __________ Ext: ______ Mobile Phone: __________

Address: ______________________________________
Street City State Zip Code

E-Mail: ______________________ ☐ I would like to receive correspondences via e-mail

RESPONSIBLE PARTY

Name: ______________________________________
Last, First MI (Preferred Name)

Home Phone: __________ Work Phone: __________ Ext: ______ Mobile Phone: __________

Address: ______________________________________
Street City State Zip Code

☐ Responsible party is also a policy holder for patient ☐ Primary insurance policy holder ☐ Secondary insurance policy holder

EMPLOYMENT STATUS

Employer Name: ______________________ Status: Full ☐ Part ☐ Retired ☐

Address: ______________________________________
Street City State Zip Code

EMERGENCY CONTACT

Contact Name: ______________________ Mobile Phone: __________

REFERRAL INFORMATION

Whom may we thank for referring you to our office ______________________

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HEALTH INFORMATION

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores / Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells / Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack / Failure
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble / Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heatbeat
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatisim
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Spina Bifida
- ☐ Stomach /Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

OTHERS

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WOMEN ONLY

- ☐ PREGNANT/TRYING TO GET?
- ☐ TAKING CONTRACEPTIVES?
- ☐ NURSING?

Please explain conditions not listed above: ____

Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain: ____________________

Have you been hospitalized or had major surgery? ☐ Yes ☐ No If yes, please explain: ____________________

Have you had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: ____________________

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If yes, please explain: ____________________

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No ____________________

Do you take, or have you taken, Zometa or Fosamax? ☐ Yes ☐ No ____________________

Do you smoke or use other tobacco products? ☐ Yes ☐ No ____________________

Are you allergic to any of the following?

- ☐ Aspirin ☐ Penicillin ☐ Codeine
- ☐ Acrylic ☐ Metal ☐ Latex
- ☐ Local Anesthetic ☐ Other: ____________________

Comments: ____

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To the best of my knowledge, all of the preceding answers and information provided are true and correct. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my health.

______________________________ Date: _______________ Reviewed by: ____________________

Signature of patient, parent or guardian

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DENTAL HISTORY

Date of Last Dental Visit: ______________ Reason for this Visit: ______________

Are you having any discomfort on your teeth? ☐ Yes ☐ No If yes, please explain: ______________

Are your teeth sensitive to hot or cold? ☐ Yes ☐ No If yes, please explain: ______________

Have you ever had:

Orthodontic treatment? ☐ Yes ☐ No If yes, please explain: ______________

Jaw surgery? ☐ Yes ☐ No If yes, please explain: ______________

Periodontal treatment? ☐ Yes ☐ No If yes, please explain: ______________

Your occlusion (bite) adjusted? ☐ Yes ☐ No If yes, please explain: ______________

Worn an occlusal (bite) guard? ☐ Yes ☐ No If yes, please explain: ______________

Are your teeth loose? ☐ Yes ☐ No Does food lodge between your teeth? ☐ Yes ☐ No

Are your gums painful or swollen? ☐ Yes ☐ No Do they bleed when you brush? ☐ Yes ☐ No

Do you snore at night or do you suffer from sleepiness due to a sleep disorder, such as obstructive sleep apnea? ☐ Yes ☐ No

If yes, please explain: ______________

Do you clench or grind your teeth? ☐ Yes ☐ No • Do you bite your lips or cheeks? ☐ Yes ☐ No

Are you experiencing problems with your jaw joint?

Clicking of the joint? ☐ Yes ☐ No If yes, please explain: ______________

Pain (joint, ear, side of face)? ☐ Yes ☐ No If yes, please explain: ______________

Difficulty opening or closing? ☐ Yes ☐ No If yes, please explain: ______________

Difficulty chewing? ☐ Yes ☐ No If yes, please explain: ______________

Are you now under the care of a general dentist? ☐ Yes ☐ No If yes, please explain: ______________

Name of Dentist: ______________ Address: ______________ Telephone: ______________

Have you ever had any complication following dental treatment? ☐ Yes ☐ No If yes, please explain: ______________

Are you happy with the appearance of your teeth? ☐ Yes ☐ No If no, please explain: ______________

Are you interested in whitening your teeth? ☐ Yes ☐ No If yes, please explain: ______________

Are there any constraints that may severely limit your needed treatment? ☐ Yes ☐ No If yes, please explain: ______________

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