Patient History

Patient Information

Name: _____ **Today's Date**:_____

Address:_____ **City:**_____

St:_____ **Zip:**_____ **Home Phone:** _____ **Work Phone:**_____

Cell Phone:_____ **Email:**_____ **Birthdate:**_____

Social Security No.:_____ ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Preferred Contact Method: ☐ **Home Phone** ☐ **Work Phone** ☐ **Cell Phone** ☐ **Email**

Dental Insurance Information

Subscriber Name: _____ **Relation to Patient:** _____

Subscriber Birthdate: _____**Soc. Sec. #:**_____ **Home Phone:**_____

Address *(if different from patient)*: _____

City:_____ **St:**_____ **Zip:**_____ **Email:** _____

Employer:_____ **Insurance Company:**_____

Insurance Phone:_____ **Group #**_____ **Subscriber #**_____

Is patient covered by another dental insurance? ☐ **Yes** ☐ **No**

Subscriber Name: _____ **Relation to Patient:** _____

Subscriber Birthdate: _____**Soc. Sec. #:**_____ **Home Phone:**_____

Address *(if different from patient)*: _____

City:_____ **St:**_____ **Zip:**_____ **Email:** _____

Employer:_____ **Insurance Company:**_____

Insurance Phone:_____ **Group #**_____ **Subscriber #**_____

Medical History

Physician Name_____ **Phone:**_____

Sex: ☐ **Male** ☐ **Female** **Height:** _____ **Weight:**_____

If female, please answer the following:

☐ **Yes** ☐ **No** Are you taking Birth Control Pills?

☐ **Yes** ☐ **No** Are you pregnant? If Yes, # of weeks _____

☐ **Yes** ☐ **No** Are you nursing?

☐ **Yes** ☐ **No** **Do you smoke or use tobacco?**

For Office Use Only:

BP:_____ **Heart Rate:** _____

Allergies:

☐ **Yes** ☐ **No** Aspirin ☐ **Yes** ☐ **No** Metals

☐ **Yes** ☐ **No** Codeine ☐ **Yes** ☐ **No** Penicillin

☐ **Yes** ☐ **No** Dental Anesthetics ☐ **Yes** ☐ **No** Tetracycline

☐ **Yes** ☐ **No** Erythromycin **Other:** _____

☐ **Yes** ☐ **No** Jewelry _____

☐ **Yes** ☐ **No** Latex _____

Please list any MEDICATIONS you are currently taking:

Conditions:

☐ **Yes** ☐ **No** AIDS/HIV Positive	☐ **Yes** ☐ **No** Epilepsy	☐ **Yes** ☐ **No** Psychiatric Care
☐ **Yes** ☐ **No** Abnormal Bleeding	☐ **Yes** ☐ **No** Fainting Spells	☐ **Yes** ☐ **No** Radiation/Chemotherapy
☐ **Yes** ☐ **No** Alcohol/Chemical Dependency	☐ **Yes** ☐ **No** Frequent Headaches	☐ **Yes** ☐ **No** Respiratory Disease
☐ **Yes** ☐ **No** Allergies	☐ **Yes** ☐ **No** Glaucoma	☐ **Yes** ☐ **No** Rheumatic Fever
☐ **Yes** ☐ **No** Anemia	☐ **Yes** ☐ **No** Hay Fever	☐ **Yes** ☐ **No** Seizures
☐ **Yes** ☐ **No** Angina Pectoris	☐ **Yes** ☐ **No** Heart Attack	☐ **Yes** ☐ **No** Shingles
☐ **Yes** ☐ **No** Arthritis	☐ **Yes** ☐ **No** Heart Murmur	☐ **Yes** ☐ **No** Shortness Of Breath
☐ **Yes** ☐ **No** Artificial Heart Valve	☐ **Yes** ☐ **No** Heart Surgery	☐ **Yes** ☐ **No** Sickle Cell Disease
☐ **Yes** ☐ **No** Artificial Joints	☐ **Yes** ☐ **No** Hemophilia	☐ **Yes** ☐ **No** Sinus Problems
☐ **Yes** ☐ **No** Asthma	☐ **Yes** ☐ **No** Hepatitis	☐ **Yes** ☐ **No** Stroke
☐ **Yes** ☐ **No** Cancer	☐ **Yes** ☐ **No** High Blood Pressure	☐ **Yes** ☐ **No** Thyroid Problems
☐ **Yes** ☐ **No** Circulatory Problems	☐ **Yes** ☐ **No** Kidney Disease	☐ **Yes** ☐ **No** Tobacco Habit
☐ **Yes** ☐ **No** Colitis	☐ **Yes** ☐ **No** Liver Disease	☐ **Yes** ☐ **No** Tuberculosis
☐ **Yes** ☐ **No** Congenital Heart Defect	☐ **Yes** ☐ **No** Low Blood Pressure	☐ **Yes** ☐ **No** Ulcers
☐ **Yes** ☐ **No** Cortisone Treatments	☐ **Yes** ☐ **No** Mitral Valve Prolapse	☐ **Yes** ☐ **No** Venereal Disease
☐ **Yes** ☐ **No** Diabetes	☐ **Yes** ☐ **No** Nervous Problems	☐ **Yes** ☐ **No** Yellow Jaundice
☐ **Yes** ☐ **No** Emphysema	☐ **Yes** ☐ **No** Pace Maker	

Dental History

What is the reason for today's visit?_____

Whom May we thank for referring you?_____

Former Dentist:_____ **Date of last dental visit/xrays:**_____

How often do you brush? _____

How often do you floss? _____

Do you have any of the following?

Choose all that apply:

☐ Bad Breath	☐ Food collection between teeth	☐ Periodontal treatment	☐ Sensitivity to sweets
☐ Bleeding gums	☐ Grinding teeth	☐ Sensitivity to cold	☐ Sensitivity when biting
☐ Clicking or popping jaw	☐ Loose teeth/broken fillings	☐ Sensitivity to heat	☐ Sores or growths in mouth

How would you rate your smile on a scale of 1 -10? _____

Do you feel uncomfortable or self-conscious about your smile? ☐ **Yes** ☐ **No**

Do you cover your mouth when you talk or smile? ☐ **Yes** ☐ **No**

Do you like the color of your teeth? ☐ **Yes** ☐ **No**

Do you like the shape of your teeth? ☐ **Yes** ☐ **No**

Can you see dark restorations in your teeth when you smile? ☐ **Yes** ☐ **No**

Do you have spaces between your teeth that bother you? ☐ **Yes** ☐ **No**

Are your teeth too crowded? ☐ **Yes** ☐ **No**

Signature:_____ Date:_____

(If Under 18, Parent or Guardian Signature Required)