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## WELCOME TO OUR PRACTICE

**NAME**______________________________________________ **SEX: M F**

**NAME YOU PREFER TO BE CALLED**__________________ **DATE OF BIRTH:**__/__/__

**HOME ADDRESS:**________________________________________________

________________________________________**ZIP CODE**__________

**HOME TELEPHONE**__________ **WORK TELEPHONE** __________

**CELL PHONE**_________________ **email ADDRESS**____________________________

**EMPLOYER**__________ **OCCUPATION:**_________________

**NAME OF SPOUSE/PARENT**____________ **PARTY RESPONSIBLE FOR PAYMENT**______

**WHO MAY WE THANK FOR REFERRING YOU?** ________________________________

**YOUR HOBBIES, INTERESTS, PETS, ETC.**____________________________________

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***MEDICAL AND DENTAL HISTORY***

***GENERAL HEALTH: EXCELLENT GOOD FAIR POOR***

***PHYSICIAN'S NAME***______________***PHONE #***_________________________
***WHAT IS THEIR SPECIALTY?***_________

***YEAR OF LAST PHYSICAL***_____ ***CURRENTLY BEING TREATED FOR***______________

***LIST ANY MEDICINES YOU ARE TAKING NOW (over if necessary)***_____________
______________________________________________________________________

***DO YOU HAVE ALLERGIES TO:PENICILLIN CODEINE NOVOCAINE LATEX PAIN (PLEASE CIRCLE) ANYTHING ELSE***____________________

***WOMEN: ARE YOU NURSING?***____***PREGNANT?***____ ***IF YES, HOW MANY WEEKS***_______
***DO YOU TAKE MEDS FOR OSTEOPOROSIS? (Fosamax, other?)***

***NAME AND ADDRESS OF PREVIOUS DENTIST*** ____________________

_____________________________________

***Telephone #*** __________ _____________________________________

***WOULD YOU LIKE FOR US TO REQUEST YOUR PREVIOUS DENTAL RECORDS?***________

## *MEDICAL AND DENTAL HISTORY (CONTINUED)*

*HAVE YOU BEEN TOLD BY ANYONE THAT YOU NEED TO BE PREMEDICATED BEFORE DENTAL TREATMENT? ___________________IF YES, WHY?______________________*

*PLEASE CIRCLE (YES OR NO) IF YOU HAVE HAD ANY OF THESE CONDITIONS:*
*IF CIRCLED, INDICATE APPROXIMATE AGE OF ONSET.*

| | | | |
|---|---|---|---|
| *HEART TROUBLE/MURMUR* | *YES NO* | *FAINTING SPELLS* | *YES NO* |
| *MITRAL VALVE PROLAPSE* | *YES NO* | *RHEUMATIC FEVER* | *YES NO* |
| *HIGH /LOW BLOOD PRESSURE* | *YES NO* | *JOINT REPLACEMENT* | *YES NO* |
| *PACEMAKER /CHEST PAIN* | *YES NO* | *HERPES/COLD SORES* | *YES NO* |
| *ANEMIA/ABNORMAL BLEEDING* | *YES NO* | *GONORRHEA/SYPHILIS* | *YES NO* |
| *DIABETES type I / II* | *YES NO* | *LIVER/KIDNEY TROUBLE* | *YES NO* |
| *POSITIVE TUBERCULOSIS TEST* | *YES NO* | *STROKE* | *YES NO* |
| *ASTHMA OR HAY FEVER* | *YES NO* | *EPILEPSY/SEIZURES* | *YES NO* |
| *HEPATITIS/JAUNDICE* | *YES NO* | *POSITIVE TEST FOR HIV* | *YES NO* |
| *ARTHRITIS* | *YES NO* | *AIDS/ HIV infection* | *YES NO* |
| *GLAUCOMA* | *YES NO* | *THYROID PROBLEMS* | *YES NO* |
| *SINUS PROBLEMS* | *YES NO* | *CANCER TX/ RADIATION* | *YES NO* |
| *SHORTNESS OF BREATH* | *YES NO* | *REFLUX/ULCERS/GI ISSUES* | *YES NO* |
| *SLEEP APNEA/DISORDER* | *YES NO* | *OTHER________________________* | |

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**IT IS NATURAL TO HAVE SOME ANXIETY ABOUT DENTAL TREATMENT. IS THERE ANYTHING WE CAN DO OR NOT DO TO MAKE YOUR VISITS ANY MORE PLEASANT?**

____________________________________________________________________

**ANY RECOMMENDED DENTAL CARE THAT YOU HAVE YET TO COMPLETE? (LIST AS YOU ARE ABLE)**____________________________________________________________

**HOW CAN WE HELP YOU?**_________________________________________________

**DATE OF LAST DENTAL VISIT (APPROXIMATE)______ DENTIST NAME_____________**

**I BRUSH MY TEETH ___ TIME(S) PER DAY AND FLOSS (DAILY/ __X/WEEK /NEVER)**

**OTHER DENTAL PRODUCTS YOU USE:**______________________________________

**CIRCLE THE NUMBER OF ALL THAT APPLY TO YOU:**
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1. X-RAYS TAKEN IN LAST 3 YEARS: IF YES, CIRCLE ONE OR MORE BELOW. "BITEWINGS" / PANORAMIC / FULL SERIES / I CAN'T REMEMBER
2. ORTHODONTIC TREATMENT (BRACES) (AT WHAT AGE ?______)
3. I HAVE DENTURES THAT ARE REMOVABLE/
4. SOME TEETH ARE SENSITIVE-IF YES, CIRCLE (HOT/COLD/SWEETS/ PRESSURE)
5. TOOTHACHE OR PAIN CIRCLE (TMJ(JAW JOINTS)/ FACE/ NECK/ SINUSES)
6. JAW JOINT CLICKS- IF YES, CIRCLE (ON CHEWING / OPENING)
7. CLENCH OR GRIND TEETH- IF YES, CIRCLE (DAY / NIGHT)/HAVE NIGHTGUARD
8. I RATE MY SMILE: (POOR) 1 2 3 4 5 6 7 8 9 10 (GREAT)/JUST AS I WANT
9. WOULD LIKE TO CHANGE THE APPEARANCE OF SOME TEETH
10. FOOD CATCHES BETWEEN SOME TEETH
11. GUMS BLEED ON BRUSHING
12. I HAVE BEEN TOLD I HAVE GUM DISEASE (TREATMENT DATE IF ANY_____)
13. I HAVE DRY MOUTH - MODERATE / SEVERE

**I certify that the above information is correct.**

**PATIENT SIGNATURE**__________________________________ ***THANK YOU!***