Welcome

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General Dentistry

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ABOUT YOU

Patient's name: ______________________________
Last First MI

Address: ______________________ City __________ State ______ Zip Code _______

Preferred name: ________________ Sex ☐ M ☐ F

Birth Date: ____________ SSN # ________________

Marital Status ☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Minor

Occupation: ______________________________

Employer/School: ______________________________

Spouse's name: ______________________________
Last First MI

Spouse's Birth Date: ____________ Spouses' SSN# ____________

Spouse's Employer: ______________________________

Home phone: ______________________________

Cell phone: ______________________________

Work phone: ______________________________

Email: ______________________________

IN CASE OF EMERGENCY

Name: ______________________________

Relation ______________________________

Phone: ______________________________

Whom may we thank for referring you?

____

YOUR INSURANCE

Who is responsible for this account?________________ Relation ________________

Do you have dental insurance? ☐ Yes ☐ No

Primary Insurance Co: ________________ Group # ________________

Do you have a copayment? ☐ Yes ☐ No Copayment $________________

Secondary Insurance Co: ________________ Group # ________________

Do you have a copayment? ☐ Yes ☐ No Copayment $________________

YOUR DENTAL HISTORY

Reason for todays visit: ______________________________

Previous Dentist: ________________City: ________________ State ________

Date of last dental visit ________________ Date of last dental x-rays________________

How would you describe your current oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is there anything about your smile that you wish you could change? ☐ Yes ☐ No

Describe:______________________________

Please check yes or no to indicate if you have had any of the following:

Toothache	☐ Yes ☐ No	Burning Sensation in Tongue	☐ Yes ☐ No	Fillings	☐ Yes ☐ No
Sensitive to Cold	☐ Yes ☐ No	Loose Teeth	☐ Yes ☐ No	Scaling and Root Planning	☐ Yes ☐ No
Sensitive to Hot	☐ Yes ☐ No	Smoke	☐ Yes ☐ No	Root Canal	☐ Yes ☐ No
Pain when Chewing	☐ Yes ☐ No	Chew Tobacco	☐ Yes ☐ No	Crown	☐ Yes ☐ No
Sensitive to Sweets	☐ Yes ☐ No	Nail Biting	☐ Yes ☐ No	Bridge	☐ Yes ☐ No
Swollen/Bleed Gums	☐ Yes ☐ No	Thumb Sucking	☐ Yes ☐ No	Dental Implant	☐ Yes ☐ No
Jaw Pain	☐ Yes ☐ No	Food Stuck in Teeth	☐ Yes ☐ No	Tooth Extraction	☐ Yes ☐ No
Clicking/Popping Jaw	☐ Yes ☐ No	Cheekbiting	☐ Yes ☐ No	Gum Surgery	☐ Yes ☐ No
Ear Pain	☐ Yes ☐ No			Partial Denture	☐ Yes ☐ No
Mouth or Lip Sores	☐ Yes ☐ No			Full Dentures	☐ Yes ☐ No

How often do you brush? ________ How often do you floss?____________

Do you use any other cleaning aids? ________________________

YOUR MEDICAL HISTORY

GENERAL

Smoke/Chew Tobacco	☐ Yes	☐ No
Alcohol or Drug Abuse	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemotherapy or Radiation	☐ Yes	☐ No
Persistent Fever	☐ Yes	☐ No
Change in Weight	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No

MUSCULOSKELETAL

Arthritis	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No

GENITOURINARY

Kidney Disease	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No
Veneral Disease	☐ Yes	☐ No

EYES

Blurred or Double Vision	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

SKIN

Rash or Eczema	☐ Yes	☐ No

EAR, NOSE, THROAT & MOUTH

Ear Infection	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Frequent Nosebleeds	☐ Yes	☐ No
Sore Throat	☐ Yes	☐ No
Lump in Neck	☐ Yes	☐ No
Seasonal Allergies	☐ Yes	☐ No

NEUROLOGIC

Migraine Headaches	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Dizziness or Fainting	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No

RESPIRATORY

Asthma	☐ Yes	☐ No
Persistent or Bloody Cough	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No

ENDOCRINE

Thyroid Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No

CARDIOVASCULAR

Chest Pains	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Heart Palpitations	☐ Yes	☐ No
Infective Endocarditis	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No
Congential Heart Defect	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No

GASTROINTESTINAL

Acid Reflux	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Hepatitis (Type ___)	☐ Yes	☐ No

PSYCHIATRIC

Depression	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Bipolar Disorder	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No

WOMEN

Are You Pregnant?	☐ Yes	☐ No

MEDICATIONS

Are you currently taking any prescription or over the counter medications? ☐ No ☐ Yes

List medications below:

Name	Dose	How often taken

If additional room is needed, a separate page may be attached.

Have you ever taken any bisphosphanate medications (Fosamax, Actonel, Boniva or Zometa) for osteoporosis or other bone disorders?

☐ Yes ☐ No

Have you taken any of the weight-loss drugs collectively referred to as “Fen-Phen”?

☐ Yes ☐ No

Where do you fill prescriptions?

Pharmacy: ______________________________

Phone: ______________________________

ALLERGIES

Have you had hives, skin rash, breathing problems or other allergic reactions to medications? ☐ Yes ☐ No

List medications below:

Name	Describe reaction

If additional room is needed, a separate page may be attached.

Have you had an allergic reaction to latex? ☐ No ☐ Yes

Are there medications, other than those you are allergic to, that you would prefer not to take due to prior unpleasant side effects? ☐ No ☐ Yes

If yes, please specify:

HAVE YOU EVER BEEN HOSPITALIZED OR HAD ANY SURGERIES?

Surgeries:

Reason	Year
Reason	Year

Hospitalizations

Reason	Year
Reason	Year