Welcome! The benefits of a healthy smile are immeasurable! Our practice is based on preventive care. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime. We are committed to strict infection control procedures.

ABOUT YOU

Name: _____

I prefer to be called: _____

M ( ) F ( ) Birthdate: _____

Marital Status: S M D W SEP

Social Security #: _____

Email: _____

Address: _____

City/State: _____ Zip: _____

Home #: _____ Cell #: _____

Work #: _____ Ext.: _____

EMPLOYER: _____

Employer's Address: _____

_____

Occupation: _____

How long there? _____ Best time and

place to reach you? _____

Other family seen by us: _____

Who may we thank for referring

you? _____

SPOUSE INFORMATION

Their Name: _____

Birthdate: _____

Employer: _____

Work #: _____ Ext.: _____

Cell #: _____

DENTAL HISTORY

Do you have any dental problems now? _____

_____

Are you in pain? Yes No

Adverse reaction to dental work? Yes No

_____

Pain in jaw joint (TMJ/TMD)? Yes No

Chewing tabacco? Yes No _____/ day for _____years

Smoking? Yes No _____packs/ day for _____years

Vaping? Yes No _____/ day for _____years

Drinking? Yes No _____ mild (occasional)

_____ moderate (2/day men, 1/day women)

_____ heavy (14/week men, 7/week women)

Marijuana? Yes No _____ inhaled

_____ pill or oil (medical)

_____ edible

____ daily ____occasional ____ rarely

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Have you every been told you have periodontal (gum) disease? Yes No

How often do you brush? _____ Floss? _____

Type of bristles? Hard Medium Soft

What other dental aids do you use?
(Waterpik, toothpick, Sonicare, etc.)

_____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone #: _____

OVER PLEASE ----------→

MEDICAL HISTORY

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Y N Heart attack – If yes, year_____
Y N Heart surgery – _____
Y N Previous endocarditis
Y N Heart pacemaker
Y N Congenital heart defect
Y N Artificial valve or vessel
Y N Gortex lining for aneurysm repair
Y N HIV/AIDS
Y N Stent
Y N Shunt
Y N Thyroid
Y N Artificial joints (hip, knee, etc.) – If yes, year_____
Y N Stroke– If yes, year_____
Y N STD/HPV
Y N Hepatitis
Y N Cholesterol
Y N Kidney problems
Y N Broken bones
Y N High blood pressure
Y N Low blood pressure
Y N Cold sores / fever blisters
Y N Sinus problems
Y N Severe/frequent headaches
Y N Psychiatric problems
Y N Epilepsy/seizures/fainting
Y N Diabetes
Y N Tuberculosis
Y N Drug/alcohol abuse
Y N Ulcers/colitis
Y N Hemophilia/abnormal bleeding
Y N Anemia
Y N Arthritis
Y N Asthma
Y N Difficulty breathing
Y N Alzheimer's/Dementia
Y N Blood transfusion
Y N Take Oral / IV bisphophonates for osteoporosis
Y N Cancer
Y N Radiation treatment
Y N Chemotherapy
Y N IV Port
Y N Dialysis
Y N Organ / Pre-organ Transplant

Other? _____

Allergic to any of the following?

Y	N	Penicillin	Y	N	Tetracycline
Y	N	Aspirin	Y	N	Novocaine
Y	N	Codeine	Y	N	Erythromycin
Y	N	Latex	Y	N	Sulfa

Other? _____

_____

Physician's Name: _____

Phone #:_____

Last Visit:_____

Current Health: Good Fair Poor

Currently under doctor's care? Yes No

Why? _____

Taking any medications at this time? List: _____

_____

_____

Hospitalized for any reason? _____

_____

Please list any serious medical condition you have had, or have at present.

_____

_____

Are you using any Herbal Supplements? List: _____

_____

WOMEN: Taking Birth Control Pills? Y N

Pregnant? Y N Months:_____Nursing? Y N

I have read and understand the above information is necessary to provide dental care in a safe and efficient manner. I have answered all the questions accurately to the best of my knowledge. I understand it is my responsibility to inform the dentist of any changes in medical status. I authorize the dental office to administer any necessary treatment needed for proper dental care. I authorize payment to the dental office for services rendered, and understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the dentist to release dental/ medical histories and other information about dental treatment to third party payers and/or other health professionals.

Patient/Guardian Signature _____ *Date* _____

OFFICE USE - REVIEW

UPDATES

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____