PERSONAL INFORMATION

Name: _____ Nickname: _____

Address:_____

Occupation: _____ Marital Status _____ Gender: M / F

Home Phone: _____ Social Security Number: _____

Work Phone: _____ Birthdate: _____/_____/_____

Cell Phone: _____ Email: _____

EMERGENCY INFORMATION

In Case of Emergency, whom should we contact on your behalf?

Name: _____ Relationship: _____ Phone: _____

MEDICAL HISTORY

Primary physician: _____ Phone: _____

Are you currently being treated by a physician? □Yes □ No

If so, for what condition? _____

Have you had major or minor surgery in the past five years? □Yes □ No

Have you ever fainted or had seizures? □Yes □ No

Please check any/all conditions that apply:

□ Chest Pain	□ Hepatitis or Jaundice	□ Asthma, T.B.
□ Heart Murmur	□ Positive HIV Test	□ Thyroid Imbalance
□ Mitral Valve Prolapse	□ Glaucoma	□ Venereal Disease
□ Rheumatic Fever	□ Kidney Disease	□ Stomach Ulcers
□ Cardiac Pacemaker	□ Sinus Problem	□ Severe Anxiety

□ High Blood Pressure □ Prosthetic Joints □ Psychiatric Therapy

□ Blood Disorders (Anemia, etc) □ Cancer/Radiation Treatment □ Arthritis

□ Abnormal Bleeding □ Diabetes □ Latex Allergy

Are you currently taking or have you previously taken bisphosphonate medications such as **Actonel**, **Fosomax**, or **Boniva** within the past twelve years?

□Yes □ No

Are you taking any medications?

□Yes □ No If yes, please list: _____

Do you have any allergies? (including medications such as antibiotics and pain relievers)

□Yes □ No If yes, please list: _____

DENTAL HISTORY

Please check any/all following conditions that apply:

□ Dental Implants □ Jaw pain (TMD)

□ Electric Toothbrush Use □ Periodontal Disease (past/current)

□ History of Root Canal(s) □ Wisdom Teeth Extraction

□ History of Orthodontics (Braces/Invisalign®) □ Teeth Grinding / Bruxism

□ Teeth Whitening (in-office / trays / strips)

Have you ever had to take pre-medication prior to a dental appointment, such as antibiotic prophylaxis?

□Yes □ No If yes, please explain: _____

Have you ever had any complications following dental treatment?

□Yes □ No If yes, please explain: _____

Is your spouse currently a patient? If so what is their name: _____

What is your primary reason or concern for contacting us? _____

Approximate last date of dental visit: _____ Reason: _____

Whom may we thank for referring you to our practice? _____

Women: Is there a possibility you are currently pregnant? □Yes □ No

If yes, please provide current trimester: _____ Estimated due date: _____

1. Are you interested in whitening your teeth? □Yes □ No
2. Are you interested in straightening your teeth? □Yes □ No
3. Are you interested in improving your smile? □Yes □ No
4. Are you interested in knowing more about the benefits of an electric toothbrush? □Yes □ No
5. Are you interested in replacing missing teeth? □Yes □ No
6. Are you interested in fluoride varnish treatment? □Yes □ No
7. Do you grind or clench your teeth? □Yes □ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status

Signature of patient, parent or guardian:_____ Date:_____.