welcome to our practice

please fill out this form completely; we are happy to answer any questions

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ABOUT YOU

Patient's Name _____
Preferred Name _____ Male Female
Birthdate ___/___/____ Age_____ SS #_____ - _____ - _____
Address _____
City _____ State ____ Zip _____
Email _____
Home # _____ Mobile #_____
Whom may we thank for referring you?_____
Where did you hear about us?_____
Other family members seen by us _____
Employer or Occupation_____

SPOUSE INFO

Name _____
Home # _____
Mobile # _____ Birthdate___/___/___
Email_____

FOR MINORS

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____
Home # _____ Work # _____
Mobile # _____ Birthdate___/___/___
Email _____
Billing Address _____
City _____ State ____ Zip_____

INSURANCE

Insurance Company _____
Phone # _____
Group # _____
ID# _____
Insured's Name (if different) _____
Relation _____
**If you have a secondary insurance please let us know

MEDICAL HISTORY

I. Circle appropriate answer

1. Yes / No Is your general health good?
   If NO, explain_____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain_____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain_____
4. Yes / No Are you being treated by a physician now?
   If YES, explain_____
   Date of last medical exam?_____ Reason for exam_____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain_____
   Date of last dental exam_____ Name of last treating dentist_____
6. Yes / No Are you in pain now?
   If YES, explain_____

II. Have you had any of the following medical problems or treatments?

AIDS/HIV	Yes No	Eye disease	Yes No	Mental disorder	Yes No
Anemia	Yes No	Fainting or Dizziness	Yes No	Osteoporosis	Yes No
Angina (chest pain)	Yes No	Family history of diabetes	Yes No	Radiation	Yes No
Anxiety	Yes No	Family history of heart disease	Yes No	Respiration problem	Yes No
Arterial / Vascular Disease	Yes No	Frequent cough	Yes No	Rheumatic fever	Yes No
Arthritis, rheumatism	Yes No	Headaches	Yes No	Seizure	Yes No
Asthma	Yes No	Head injury	Yes No	Sexual transmitted disease	Yes No
Bleeding problems / Hemophilia	Yes No	Heart attack	Yes No	Shortness of breath	Yes No
Blood disease	Yes No	Heart disease or defect	Yes No	Sinus problems	Yes No
Blurred vision	Yes No	Heart murmur	Yes No	Skin disease	Yes No
Bruise easily	Yes No	Hepatitis	Yes No	Sleep Apnea	Yes No
Cancer	Yes No	Herpes	Yes No	Snoring	Yes No
Chemotherapy	Yes No	High blood pressure	Yes No	Stomach problems or ulcers	Yes No
Cold sores/ fever blisters	Yes No	High Cholesterol	Yes No	Stroke	Yes No
Depression	Yes No	Jaundice	Yes No	Swollen ankles	Yes No
Diabetes	Yes No	Joint replacement	Yes No	Thyroid disease	Yes No
Ear Problems	Yes No	Kidney or bladder disease	Yes No	Transplants	Yes No
Eating disorders	Yes No	Liver disease	Yes No	Tuberculosis	Yes No
Excessive thirst	Yes No	Lung disease -	Yes No	Tumors or growths	Yes No

IV. Are you allergic to or have you had a reaction to any of the following?

Aspirin	Yes No	Anesthetic (Novocain)	Yes No	Tetracycline	Yes No
Codeine	Yes No	Penicillin	Yes No	Nitrous oxide	Yes No
Latex	Yes No	Sulfa Drugs	Yes No	Other_____	

V. Are you taking or have you taken any of the following in the last three months?

Recreational drugs	Yes No	Tobacco in any form	Yes No	Supplements	Yes No
Over-the-counter medicines	Yes No	Alcohol	Yes No	Aspirin	Yes No
Weight loss medications	Yes No	Bisphosphonate (Fosamax)	Yes No		
Cortico-steroids	Yes No	Antibiotics	Yes No		

Please list all medications you are currently taking_____

VI. Women only

Are you or could you be pregnant? Yes No
If YES, what month?_____
Are you nursing? Yes No
Are you taking birth control pills? Yes No

VII. All Patients

1. Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
   If YES, explain_____
2. Yes / No Have you ever been pre-medicated for dental treatment?
   If YES, why_____
3. Yes / No Have you ever taken Fen-Phen?
   If YES, when_____
4. Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?

DENTAL HISTORY

Why have you come to the dentist today?_____
Has a dentist told you that you require antibiotics before dental treatment? Yes No
Are you currently in pain? Yes No
Have you ever had a serious or difficult problem associated with any previous dental work? Yes No
Have you ever experienced pain or discomfort in your jaw joint (TMJ/ TMD)? Yes No

Your dental health is Good Fair Poor
Do you like your smile? Yes No
Do your gums bleed? Yes No
Do you have dry mouth Yes No
How many times a week do you floss? _____
How many times a day do you brush? _____
Type of toothbrush bristles? Hard Medium Soft

We are offering a variety of new services in our office. Are you interested in discussing about:

_____ **Invisalign** _____ **Sleep Apnea, non-CPAP treatment options**

_____ **Dental Implants** _____ **Teeth Whitening options**

I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature _____ Date_____

Doctor's Name_____ Phone Number_____

Medical updates *(To be completed at future visits)*

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to your Health	Dentist Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____