PLEASE PRINT CLEARLY

Mr / Mrs / Ms / Miss (circle) Male / Female (circle)

First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: MM/DD/YYYY _____

Address: _____

City: _____ Postal Code: _____ Email: _____

Home #: _____ Bus. #: _____ Cell #: _____

How did you hear about our clinic? _____

Employer / School: _____

Do you have dental insurance? Y N Do you have a 2nd dental insurance? Y N

DENTAL HISTORY

What is your main reason for seeking dental treatment today? _____

Date of last dental visit: _____ Date of last x-ray: _____

Have you ever had any of the following? (please circle):

Jaw Surgery Orthodontic Treatment Splint/Nightguard Wisdom Teeth Extracted Motor Vehicle Accident

Do you have any sore, aching, or sensitive teeth? Y N Do your gums bleed when brushing or eating? Y N

Has your jaw ever locked? Y N

Have you ever experienced any of the following jaw problems? (please circle):

Popping/clicking in your jaw joints Pain in your jaw joint Pain around your ear or the side of your face

Difficulty in opening or closing Pain when teeth are clenched Pain or difficulty while chewing

Do you have any of the following habits? (please circle):

Clenching or grinding your teeth while awake or asleep Biting your cheeks or lips Mouth breathing while awake or sleep

Placing foreign objects in your mouth (pencils pens nails pipes pins finger nails)

Do you have any emotional concern about having dental treatment? Y N

If Yes, please explain: _____

Do you have any questions or concerns? _____

_____

_____

MEDICAL HISTORY

Are you in good health now? Y N If no, please explain: _____

_____

Have you recently, or are you presently, taking any prescriptions or non-prescription drugs incl. health remedies? Y N
If Yes, please list: _____

_____

Have you ever reacted adversely to any medications or injections?
Penicillin Codeine Local Anesthetic Sulpha Drugs Aspirin Other

Have you ever been advised against taking any specific type of medication? Y N

Do you have any of the following? (please circle):
Asthma Hay Fever Food Allergies Metal Allergies Latex Allergies Skin Rashes Hives Other

Do you bleed excessively from a cut or injury? Y N Do you bruise easily? Y N

Have you tested HIV positive? Y N Do you smoke? Y N

Are you alcohol and/or drug dependent? Y N

Indicate which of the following you presently have or ever had (please circle):

AIDS Anemia Angina pectoris Arthritis/rheumatism Artificial joints (hip knee) Blood disorders
Bronchitis Cancer Circulation problems Congenital heart lesions Cortisone/steroid Crohn's disease
Diabetes Emphysema Epilepsy or seizures Fainting or dizzy spells Glandular disorders Glaucoma
Head/neck injuries Heart disease or attack Heart murmur Heart pacemaker Heart rhythm disorder
Hepatitis A Hepatitis B Hepatitis C Herpes High blood pressure Low blood pressure
Hodgkins disease Hyper glycemia Hypertension Inflammatory bowel disease Jaundice Kidney disease
Liver disease Lung disease Lupus Malignant hyperthermia Mental/nervous disorder
Mitral valve prolapse Organ transplant Psychiatric treatment Radiation treatment/chemotherapy
Scarlet fever Rheumatic fever Sickle cell disease Sinus trouble Stomach/intestinal problems/ulcers
Stroke Thyroid disease Tuberculosis Venereal disease Measles Mumps Chicken Pox
Strep throat Tonsillitis Cold Sores

Do you currently have, or have you had in the past, any disease, condition or problem not listed above? Y N

If Yes, please explain: _____

Is there anything else about your health we should be aware of? Y N

If Yes, please explain: _____

Women Only (please circle): N/A

Are you pregnant? Due Date: _____ Are you breast feeding? Are you taking any birth control pills?