



PATIENT'S NAME

DATE M/D/YR

PAGE 1. OF 3

EMAIL ADDRESS

MALE FEMALE

PHONE#

DATE OF BIRTH

SS#

CELL

Street Address

City

ZIP

Billing Address

City

ZIP

EMPLOYER

City Occupation

PHONE#

Bus. Address

City

ZIP

Dental Ins.

GROUP#

POLICY#

PHONE#

Ins. Address City, State, & Zip

SPOUSES NAME

DATE OF BIRTH

SS#

Bus. Address

City

ZIP

Dental Ins.

GROUP#

POLICY#

PHONE#

Ins. Address City, State, & Zip

REFERRED BY?



DENTAL INFORMATION

1. Previous dentist:

2. Date of last visit: m/d/yr

3. When was your last Full Mouth X-ray taken?

4. When was your last Dental Cleaning?

5. Frequency of dental exams? (how often)

6. Have you had any unfavorable re-action from previous dental treatment? YES NO

IF YES Explain? Describe:

7. Do you have any present dental complaints? YES NO

8. What made you decide to make this dental appointment?

9. Frequency of brushing?

10. Frequency of flossing?

11. Do you use fluoridated toothpaste?

12. What are some typical foods you eat between meals?

13. What types of beverages do you typically drink between meals?

14. How often do you chew or suck on hard candy, cough drops or mints?

15. Primary source of drinking water? A. City Water Filtered B. City Water Unfiltered, C. Bottled Water D. Well Water A,B,C, or D? >

MARK ALL THAT APPLY

16. Have you been instructed on caring for your gums? YES

EXPLAIN

38. Do you hear popping clicking or snapping? YES

17. Have you been instructed on prevention of decay? YES

EXPLAIN

39. Do you have jaw pain? YES

18. One or more fillings in the last three years? YES

25. Have you had any dental implants placed? YES

31. Are you aware of any swelling or lumps? YES

40. Sensitive Teeth YES

19. Family history of extensive decay? YES

26. Treatment for temporomandibular disorders? YES

32. Sore, bleeding gums? YES

a.) HOT YES

20. If Child, mother's history of decay? YES

27. Do you wear a denture(s) or partial denture(s)? YES

33. Loose teeth? YES

b.) COLD YES

21. Treatment for periodontal (gum) disease? YES

DO YOU HAVE CONSISTENT PROBLEMS WITH:

34. Difficulty chewing? YES

c.) PRESSURE YES

22. Family history of periodontal disease? YES

28. Dry mouth/ excessive thirst? YES

35. Food catches between teeth? YES

23. Have you had orthodontics (braces)? YES

29. Mouth odors / bad taste? YES

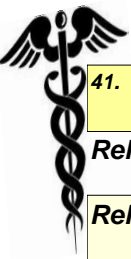
36. Teeth / filling break frequently? YES

24. Have you had oral surgery? YES

30. Cold sores / blister/ oral lesions? YES

37. Clenching or grinding habits? YES

CONTINUE TO PAGE 2. (SCROLL)



41. PreMed Required ? YES NO If YES Describe

Relative to contact in case of emergency

PHONE#

Relationship Address: City, State, & Zip

PHYSICIAN'S NAME

PHYSICIAN Address: City, State, & Zip

PHONE#

42. Are you in good health? YES NO If NO, EXPLAIN

43. Do you have an existing illness? YES NO If YES EXPLAIN

44. Under physician's care? YES NO If YES DETAILS

45. Hospitalized in the past five years? YES NO If YES, WHY?

46. WOMEN: Are you PREGNANT? YES NO If YES, DUE DATE

NURSING? YES NO ORAL CONTRA-CEPTIVES? IF YES -LIST BELOW YES

47. Taking any medication, pills or drugs (Prescription, Over The Counter & Herbal)? YES NO

LIST ALL MEDICATIONS BELOW

Table with 3 columns: MEDICATION, DOSAGE, FREQUENCY. Rows A-F.

Table with 3 columns: MEDICATION, DOSAGE, FREQUENCY. Rows G-L.

48. ALLERGY TO a.) PENICILLIN YES

If YES Describe

b.) OTHER ANTIBOTICS YES

If YES List

c.) LOCAL ANESTHETICS YES

If YES List

d.) LIST ALL MEDICATIONS YOU ARE ALLERGIC TO YES (including over the counter and herbal)

If YES List

f) LIST ALL ALLERGIES, FOOD, WEED, OR OTHER YES

If YES List

d) LATEX and/or METAL (If yes, list type) YES

If YES List

49. DO YOU TAKE DIET MEDICATION YES

If YES List

50. HAVE YOU TAKEN PHEN-FEN (DIET MED) YES

TOBACCO

51. Tobacco User ? YES a.) TYPE:

b.) AMOUNT:

c.) NUM. OF YEARS:

52. Previous attempts to quit? YES

a.) Number of attempts

b.) Longest period of success

c.) Methods used

54. Former tobacco user? YES

a.) Type

b.) Amount

c.) Year Quit

53. Interesting in quitting tobacco YES

CONTINUE TO PAGE 3. (SCROLL)

continue MARK ALL THAT APPLY PAST & CURRENT MEDICAL CONDITIONS

55. HEAD/ NECK/ MOUTH INJURIES	YES	72. BLEEDING PROBLEM	YES	88. HIGH BLOOD PRESSURE	YES	104. CONVULSIONS	YES
56. HEART Trouble DISEASE	YES	73. HEMOPHILIA	YES	89. STROKE	YES	105. EPILEPSY/ SEIZURES	YES
57. HEART MURMUR	YES	74. ANEMIA	YES	90. SLEEP APNEA	YES	106. CEREBRAL PALSY	YES
59. RHEUMATIC FEVER	YES	75. LEUKEMIA	YES	91. SINUS TROUBLE	YES	107. FAINTING-DISSINESS	YES
60. MITRAL VALVE PROLAPSE	YES	76. BLOOD DISEASE	YES	92. SHORTNESS OF BREATH	YES	108. HEADACHES	YES
61. HEART SURGERY	YES	77. AUTO IMMUNE DISEASE	YES	93. ASTHMA	YES	109. DIABETES	YES
62. ARTIFICIAL HEART VALVE	YES	78. HEPATITIS	YES	94. LUNG DISEASE	YES	a.) DIABETES TYPE 1 or 2 ?	
63. PACEMAKER OR STENT	YES	79. LIVER DISEASE	YES	95. EMPHYSEMA	YES	b.) CONTROLLED	YES
64. INDWELLING DEFIBILLATOR	YES	80. AIDS / HIV DISEASE	YES	96. TUBERCULOSIS	YES	110. STOMACH ULCER	YES
65. ARTIFICIAL JOINTS	YES	81. DRUG OR ALCOHOL RELATED ADDICTION - DISEASE	YES	97. THYROID DISEASE	YES	111. STOMACH REFLUX	YES
66. HIP PROSTHESIS	YES	82. VENERAL DISEASE	YES	98. GLAUCOMA	YES	112. EATING DISORDER	YES
67. ANY PROSTHESIS	YES	83. AUTO IMMUNE DISEASE (LUPUS, PEMPHILUS)	YES	99. TUMOR HISTORY	YES	a.) DESCRIBE	
68. HISTORY OF ORGAN TRANSPLANT	YES	84. IMMUNOLOGICAL DISEASE	YES	100. MALIGNANCIES-CANCER	YES	113. DEPRESSION	YES
69. KIDNEY DISEASE?	YES	85. SJOGRENS DISEASE	YES	101. CHEMO-THERAPY	YES	114. DEPRESSION DIAGNOSED	YES
70. DIALYSIS	YES	86. FIBROMYLAGIA	YES	102. RADIATION TREATMENT HEAD/NECK	YES	a.) DESCRIBE	
71. KIDNEY TRANSPLANT	YES	87. ARTHRITIS	YES	103. NEURO-LOGIC DISEASE	YES	115. OTHER PSY-CHIATRIC DISORDERS	YES
						a.) DESCRIBE	



30. *REMARKS

Patient Consent

CONSENT

I hereby give consent for dental treatment to the attending dentist to care for myself or I am duly authorized by the patient as his/her general agent or as the parent or guardian , to give consent of such treatment. I hereby give consent of release of medical and dental information to consulting physicians, dentists and other dental or medical personnel, as may be required in the rendering of treatment. I understand that I am financially responsible to the above named office for the services rendered. In the event of collection action I shall be responsible for any legal fees incurred.

Sign at time of visit~

Signature of Patient or responsible Party:

PRINT NAME:

M/D/YR
DATE:

AUTHORIZATION

I hereby authorize payment directly to the attending dentist of any dental benefits payable to me under the conditions of my policy for services rendered. I hereby give consent for release to authorized person of financial, dental and medical information concerning care, treatment and charges as may be required to complete all claims for benefits. I consent to whatever dental procedures and anesthetics are necessary for the treatment of the above named patient. I also assume full financial responsibility for all treatment rendered.

Sign at time of visit~

Signature of Patient or responsible Party:

PRINT NAME:

M/D/YR
DATE:

(office)
Dr.: _____
Date: _____