Please Print

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Cell Phone: _____ Date of Birth: _____

Gender: _____ Soc. Sec. #: _____

Marital Status: ____ Emergency Contact & Phone: _____

E-Mail: _____ Employer: _____

Work Address: _____ Work Phone: _____

Position or Occupation: _____ Referred By: _____

Previous Dentist: _____ Last Visit: _____

Physician: _____ Phone: _____ Last Visit: _____

Dental Insurance Company: _____ Name and SS # of Policy Holder: _____

Does Your Spouse Have a Different Dental Plan Under Which You're Covered?: _____ Ins. Co.: _____

It is important that we know about your medical and dental history. Many things have a direct bearing on your dental health. We will review this questionnaire and discuss it with you in detail. Your information will be strictly confidential.

MEDICAL HISTORY

(Write in **Y** or **N** [**YES** or **NO**] in front of **EACH** item below if you have ever had the following)

_____ - HEART CONDITION/PACEMAKER
_____ - RHEUMATIC FEVER
_____ - HEART MURMUR
_____ - MITRAL VALVE PROLAPSE
_____ - HIGH BLOOD PRESSURE
_____ - LOW BLOOD PRESSURE
_____ - CHEST PAIN
_____ - SWOLLEN ANKLES
_____ - KIDNEY CONDITION
_____ - LIVER CONDITION
_____ - THYROID CONDITION
_____ - ASTHMA
_____ - TUBERCULOSIS
_____ - SHORTNESS OF BREATH

_____ - LUNG CONDITION
_____ - JOINT REPLACEMENT
_____ - HEART VALVE REPLACEMENT
_____ - STROKE
_____ - REACTION TO CODEINE
_____ - REACTION TO PENICILLIN
_____ - REACTIONS TO OTHER DRUGS
_____ - REACTION TO LOCAL ANESTH.
_____ - CORTISONE THERAPY
_____ - ANEMIA
_____ - BLOOD DISEASE
_____ - HEPATITIS
_____ - SEIZURES
_____ - GLAUCOMA

_____ - DIABETES
_____ - NEOROLOGICAL CONDITION
_____ - MALIGNANCIES
_____ - HIV POSITIVE
_____ - SINUS CONDITION
_____ - ULCER
_____ - SEXUALLY TRANSMITTED DISEASE
_____ - TAKING BIRTH CONTROL PILLS
_____ - PREGNANT? DUE _____
_____ - EXCESSIVE BLEEDING
_____ - OSTEOPOROSIS TREATMENT (MEDS)
_____ - EXCESSIVE WEIGHT LOSS
_____ - REPEATED ORAL ULCERATIONS
_____ - ANYTHING ELSE? _____

CURRENT ALLERGIES_____ CURRENT MEDICATIONS_____ HERBAL SUPPLEMENTS_____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?_____ IF YES, FOR WHAT? _____

DENTAL HISTORY

Are you happy with your smile? _____ ***What*** would you change? _____
Are you having any discomfort at this time? _____ ***Are*** your teeth sensitive to heat? _____
to cold? _____ to sweets? _____ to chewing pressure? _____ ***How*** often do you brush your teeth? _____
Do you use dental floss? _____ how often? _____ ***Do*** your gums bleed? _____ when? _____
Does food wedge between your teeth? _____ where? _____ ***Do*** you grind or clench your teeth? _____
when? _____ ***Have*** you ever had gum treatments? _____ when? _____
Do you feel you have bad breath or an unpleasant taste in your mouth at times? _____ ***Do*** you smoke? _____
how much? _____ Do you feel particularly anxious about dental treatment? _____

I HEREBY CERTIFY THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.
Failure to accurately answer any or all of these questions may result in serious injury of even death.

_____ _____

Signature **Date**