



PATIENT INFORMATION

Date ____/____/____

Patient's Name _____ Date of Birth _____

Residence Street _____

City/State/Zip _____ Social Security Number ____-____-____

Home Telephone _____ Business Telephone _____

Patient (Guardian) Employed By _____

Business Address _____

Present Position _____ How Long _____

Name of Spouse _____

Spouse Employed By _____

Business Address _____ How Long _____

Person Responsible for Account _____

Name of Dental Insurance Company _____

Policy Number _____ Subscriber Name _____

Referring Dentist _____

DENTAL HISTORY

Do you have any inflamed or unhealed areas in or around your mouth? Yes No

Do you have any pain in or near your ears? Yes No

Do you have frequent headaches? Yes No

Do you habitually clench your teeth during the day or night? Yes No

Is any part of your mouth sore to clenching? Yes No

Is any part of your mouth sore to pressure? Yes No

Are your teeth sensitive to hot, cold or sweets? (Circle one) Yes No

Do your gums bleed? Yes No

Have you ever seen a periodontist? Yes No

Have you ever had periodontal treatment? Yes No

Do you have any teeth that are missing? Yes No

Why did you lose them? _____

Has anyone in your family had periodontal disease? Yes No

How often do you brush? _____

How often do you floss? _____

Approximate date of last dental examination: _____

Was all dental treatment completed? Yes No

Date teeth were cleaned: _____

MEDICAL HISTORY

Has there been any changed in your general health within the last year? Yes No

When was your last physical examination? _____

Are you under the care of a physician? Yes No

If yes, for what reason? _____

Have you had any serious illness or operation? Yes No

If so, what? _____

Do you have or have you had any of the following disease or problems?

- Rheumatic Fever
- Rheumatic Heart Disease
- Heart Murmur
- Cardiovascular Disease
- High Blood Pressure
- Heart Attack
- Stroke
- Congenital Heart Lesion

After mild exercise, do you have pain in the chest, or are you short of breath? Yes No

Do you get short of breath when you lie down, or do you require extra pillows when you sleep? Yes No

Do you have any of the following conditions?

- Anxiety Yes No
- Sinus trouble Yes No
- Asthma or hay fever Yes No
- Fainting spells Yes No
- Seizures Yes No
- Hepatitis Yes No
- Jaundice or liver disease Yes No
- Arthritis Yes No
- Stomach ulcer Yes No
- Tuberculosis Yes No
- Venereal disease Yes No
- Have you ever tested positive for HIV? Yes No
- Diabetes Yes No

Does anyone in your family have diabetes? Yes No

Do you go to the restroom more than six times a day? Yes No

Are you thirsty much of the time? Yes No

Do you smoke? Yes No

How much? _____ Packs per day

Do you bruise easily? Yes No

Have you ever had excessive bleeding from a cut? Yes No

Do you have any blood disorder such as anemia? Yes No

Have you had radiation treatment? Yes No

Are you taking any drugs, medicine or pills prescribed by a doctor or over the counter? Yes No

If yes, what drug? _____

Are you allergic or have you ever reacted adversely to: Yes No

(check, if any)

- Local anesthetics
- Penicillin
- Other antibiotics
- Aspirin
- Codeine
- Demerol
- Barbiturates or sleeping pills
- Any other drugs

Women:

Do you take birth control pills? Yes No

Are you pregnant? Yes No

Patient's signature _____

Medical / Dental History Reviewed by _____