



## 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

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Patient's signature \_\_\_\_\_

Medical / Dental History Reviewed by \_\_\_\_\_