☐ Dr
☐ Mr
☐ Mrs
☐ Miss
☐ Ms_____ Date_____

Last Name First Middle

Age_____

We usually address our patients by their title and surname unless they request otherwise.

I prefer to be called_____ Birthdate_____
Residence Address _____City_____Zip _____
Driver's License No _____Social Security No _____Res. Phone _____
Employed by _____Occupation _____
Business Address _____Bus. Phone _____

Marital Status _____Name of Spouse _____
Spouse employed by _____Occupation _____
Business Address _____Bus. Phone _____

Whom may we thank for referring you?_____

FINANCIAL INFORMATION

Person responsible for this account _____Relationship _____
Address _____Phone _____

If you have dental insurance, your careful answers will expedite reimbursement by your insurance company. Claims are commonly delayed or returned for incomplete information.

Name of Ins. Co. _____Group or Policy No_____
Name of policy holder _____Social Security No _____

Are you covered by another insurance plan? ☐ YES ☐ NO If yes:

Name of Ins. Co. _____Group or Policy No _____
Name of policy holder _____Social Security No _____

Preference of payment for portion of fees not covered by insurance, or if no insurance:

☐ Cash or check on day of treatment
☐ Mastercard ☐ Visa ☐ American Express
☐ Other

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services performed without previous financial arrangements must be paid for by cash or check at the time services are rendered.

GENERAL INFORMATION

NAME _____

Last First Middle Date

Your answers to this dental history questionaire will help us to understand your specific dental problems, so that we may more effectively treat you with consideration for your individual needs.

Previous Dentist _____ Specialty _____

Address _____ Phone _____

Last dental visit _____ Last full mouth X-rays _____

Why did you leave your previous dentist? _____

Purpose of this visit (your immediate dental concern)? _____

Please check Yes or No:

1.	Are you presently in pain? ☐ Teeth ☐ Jaw ☐ Face ☐ Gums	☐ YES	☐ NO
2.	Is any part of your mouth sensitive to: ☐ Hot ☐ Cold ☐ Sweet ☐ Pressure	☐ YES	☐ NO
3.	Have you ever had periodontal treatment or gum surgery?	☐ YES	☐ NO
4.	Have you ever been informed that you have gum problems?	☐ YES	☐ NO
5.	Do your gums bleed when you brush your teeth?	☐ YES	☐ NO
6.	Does food catch between your teeth?	☐ YES	☐ NO
7.	Are you aware of a bad taste or odor in your mouth?	☐ YES	☐ NO
8.	Do you have frequent headaches and/or neckaches?	☐ YES	☐ NO
9.	Do you have ear pain or pain in front of the ears?	☐ YES	☐ NO
10.	Does your jaw make popping, clicking or grating noises?	☐ YES	☐ NO
11.	Are you aware that you clench your teeth during the day?	☐ YES	☐ NO
12.	Have you been told that you grind your teeth during the night?	☐ YES	☐ NO
13.	Does your jaw hurt when you open wide or take a big bite?	☐ YES	☐ NO
14.	Does the pain or discomfort interfere with sleep or daily activities?	☐ YES	☐ NO
15.	Have you ever had an occlusal adjustment or your teeth ground to improve your bite?	☐ YES	☐ NO
16.	Do you have a stiff or sore jaw upon waking in the morning?	☐ YES	☐ NO
17.	Does your jaw feel tired after a big meal?	☐ YES	☐ NO
18.	Must you chew on one side exclusively?	☐ YES	☐ NO
19.	Are you dissatisfied with the appearance of your teeth? If YES, what would you most like to change? _____	☐ YES	☐ NO
20.	Have you ever had an unfavorable reaction from local anesthetic, (Novacaine,etc.)? If YES, explain _____	☐ YES	☐ NO
21.	Have you ever had any trouble associated with any previous dental treatment? If YES, explain _____	☐ YES	☐ NO
22.	Does dental treatment make you nervous? If YES, check: ☐ Slightly ☐ Moderately ☐ Extremely	☐ YES	☐ NO

DENTAL HISTORY

NAME _____
Last First Middle Date

The thoroughness of this medical history is designed for your safety, and your complete answers will assist us in treating you with consideration for your special needs. This information will be considered confidential.

Family Physician _____ Date of last visit _____
Specialty _____
Address _____
Number Street City State Zip Code (Area Code) Phone

Other Physician _____ Date of last visit _____
Specialty _____
Address _____
Number Street City State Zip Code (Area Code) Phone

Please check YES or No.

1. Are you in good health? ☐ YES ☐ NO
2. Are you currently under the care of a physician? ☐ YES ☐ NO
   If so, what is the condition being treated? _____
3. Have you been hospitalized or had any serious illness in the past 5 years? ☐ YES ☐ NO
   If so, for what condition? _____

4. Do you have heart trouble or any form of cardiovascular disease? ☐ YES ☐ NO
   - ☐ Angina (chest pains) Frequency _____
   - ☐ Heart attack (date) _____
   - ☐ Heart surgery (date) _____
     - ☐ Pacemaker
     - ☐ Bypass
     - ☐ Prosthetic heart valve
   - ☐ Stroke (date) _____
   - ☐ Rheumatic fever(date) _____
   - ☐ Heart murmur
   - ☐ High blood pressure
   - ☐ Congenital heart lesions
   - ☐ Atherosclerosis
   - ☐ Other _____

5. Do you have any blood disease? ☐ YES ☐ NO
   - ☐ Excessive bleeding
   - ☐ Venereal disease
   - ☐ Other _____
   - ☐ AIDS or positive test
   - ☐ AIDS Related Complex (ARC)
   - ☐ Leukemia
   - ☐ Anemia

6. Do you have, or have you had any of the following?

Diabetes?	☐ YES	☐ NO	Emphysema,Asthma or breathing problem?	☐ YES	☐ NO
Hypoglycemia?	☐ YES	☐ NO	Arthritis (Rheumatoid, Osteoarthritis)?	☐ YES	☐ NO
Kidney disease?	☐ YES	☐ NO	Hip or joint replacement?	☐ YES	☐ NO
Glaucoma?	☐ YES	☐ NO	Liver disease or Jaundice?	☐ YES	☐ NO
Stomach ulcer?	☐ YES	☐ NO	Fainting spells, convulsions, epilepsy?	☐ YES	☐ NO
Intestinal ulcer?	☐ YES	☐ NO	Surgery, radiation, or other treatment for		
Tuberculosis?	☐ YES	☐ NO	a growth or tumor?	☐ YES	☐ NO
Hepatitis?	☐ YES	☐ NO	Injury or pain from your jaw joint (TMJ)?	☐ YES	☐ NO
☐ Type A Infectious (food)			Chronic head, neck or back pain problem?	☐ YES	☐ NO
☐ Type B Serum (blood)			Trauma to your head or neck?	☐ YES	☐ NO
☐ Other _____					

7. (Women) Are you pregnant? (Expected delivery date_____) ☐ YES ☐ NO
8. (Women) *Do you* have a history of previous miscarriages? ☐ YES ☐ NO
9. (Women) Are you taking birth control pills? ☐ YES ☐ NO

10. Are you allergic to, or have you had any unusual reaction to any of the following medications? ☐ YES ☐ NO

- ❑ Penicillin
- ❑ Erythromycin
- ❑ Sulfa drugs
- ❑ Other antibiotics_____
- ❑ Codeine
- ❑ Aspirin
- ❑ Other pain medications_____
- ❑ Local Anesthetics
  - ❑ Novocaine
  - ❑ Xylocaine
- ❑ Epinephrine
- ❑ Barbiturates
- ❑ Sleeping pills
- ❑ Any other drugs?_____

11. Have you ever been advised not to take a particular medication? ☐ YES ☐ NO
If yes, please list _____
12. Have you ever been advised to take antibiotics before dental treatment? ☐ YES ☐ NO
13. Please indicate if you are taking any of the following medications?

	Name	Purpose	Frequency
❑ Heart medication			
❑ Blood pressure medication			
❑ Nitroglycerine			
❑ Inderal			
❑ Antibiotics			
❑ Sedatives			
❑ Tranquilizers			
❑ Pain medication			
❑ Cortisone (Steroids)			
❑ Thyroid			
❑ Other medications			

- ❑ Alcohol (____) drinks per day
- ❑ "Recreational" drugs such as cocaine, marijuana, stimulants or depressants may have a fatal interaction with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor.

_____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility.

Signature_____ Date_____