

Purpose of Visit: _____ Date: _____

GENERAL INFORMATION

Dr., Mr., Ms., Mrs., Miss: _____ Birth Date: _____
Last First Middle

Guardian's name (if patient is a minor): _____ SSN (Pt. or Guardian): _____

Address: _____
Number Street
City State Zip Home phone: () _____

If less than one year, previous address: _____

Patient or guardian's occupation: _____ Employer: _____ No. of years: _____

Business address: _____ Work phone: () _____

Name of spouse (if applicable): _____ Spouse's occupation: _____

Spouse's employer: _____ Spouse's work phone: () _____

Number of dependents: _____ Name of nearest relative not living with you : _____

Relative's complete address: _____
Number Street
City State Zip Relative's Phone: () _____

Referred by: Relative: _____ Friend: _____ Student Health
 Yellow Pages Web Site

FINANCIAL AGREEMENT

It is expected that routine treatment be paid for at the time treatment is rendered. For your convenience, we accept personal checks, VISA and Mastercard. Financial consultation is available, prior to treatment, for appliances and major dental procedures.

Signature of financially responsible party: _____ Date: _____

INSURANCE INFORMATION

If you have any type of dental insurance, please complete.

Name of primary insurance company: _____

Name of dental plan: _____ Group No.: _____

Employee: _____ Employee's SSN: _____

Employee's date of birth: _____

Patient: _____ Relationship to employee: _____

Name of secondary insurance company: _____

Name of dental plan: _____ Group No.: _____

Employee: _____ Employee's SSN: _____

Employee's date of birth: _____

Patient: _____ Relationship to employee: _____

MEDICAL HISTORY

Name of physician: _____ City: _____ Phone: _____

Date of last medical exam: _____ Dental Exam: _____ Height: _____ Weight: _____

Do you have or are you being treated for a current medical problem? Yes No

If YES, please state the medical problem: _____

Have you ever been told you need to be pre-medicated (antibiotics) before dental appointments? Yes No

Are you disabled or handicapped? If so, please explain: _____

Women: Are you pregnant? Yes No

Have you ever been sick from, shown allergy to, or been told not to take:

YES NO

Penicillin

Codeine

Aspirin

YES NO

Antibiotics

Novacaine (or other local anesthetics)

Other drugs or medicines

Please list ALL current medications:

Dosage:

Purpose:

Have you ever had any of the following or been treated for:

YES NO

Psychotherapy

Lung trouble (TB, asthma, emphysema)

Hepatitis, liver disease

Arthritis, sore joints

Joint replacement

Diabetes

Hemophilia

Blood transfusion

Blood trouble, anemia, leukemia

Headaches when lying down

Immune system disorder/disease

HIV

Cancer

Swelling of ankles or feet

Pain, pressure or tightness in chest

Shortness of breath

YES NO

Been prescribed Fen-Phen

GI or stomach ulcer

High blood pressure

Heart attack

Mitral valve prolapse

Rheumatic fever

Heart murmur

Pacemaker

Faint spells, convulsions, epilepsy

Prolonged bleeding

Tumor

Venereal disease

Radiation treatment

Serious accident

A major operation

Other: _____

Signature: _____ Date: _____ Staff: _____

DENTAL HISTORY

YES NO

- Have you had orthodontic treatment (braces)?
- Do you have unreplaced missing teeth?
If YES, why haven't you had them replaced? _____
Date(s) of extractions: _____
- Do you have difficulty swallowing?
- Do your gums bleed when brushing your teeth?
- Have you ever been told you have gum disease?
- Have you ever had professional instructions on dental home care?
- Is any part of your mouth sensitive to temperature or pressure?
If YES, which part? _____
- Does food catch between your teeth?
If YES, where? _____
- Do you have any unpleasant odor or taste in your mouth?
- Do you smoke cigarettes? If so, how much? _____
- Do you use chewing tobacco? If so, how much? _____
- Do you drink alcohol? If so, how much per week? _____
- If there were any easy and inexpensive way to lighten your smile, would you be interested?
- If you could wave a "magic wand" and change anything about your smile, what would it be?

- Do you always have something to be treated or repaired when you visit a dentist?
- Do you feel that in the past you have required a lot of dental work? If YES, has it been to replace previous dentistry, or to repair a new decay? _____
- Are you aware that dental decay is essentially a childhood disease, and that most filling procedures are to replace broken fillings or temporary dentistry?
- Do you feel that you will lose more teeth and eventually have to wear full dentures?
If YES, at what age? _____
- Do you feel great anxiety or apprehension before having dental work?

OCCLUSAL SCREENING

YES NO

- Have you been treated for Temporomandibular Joint Syndrome (TMJ) in the past?
- Do you clench or grind your teeth during the day?
- Have you been made aware of clenching or grinding your teeth during the night?
- Do you have chronic headaches, or neck and shoulder pains?
- Do you ever notice popping or clicking in your jaw joints?
- Do you ever wake up with an awareness of your teeth or jaw as if you have had them clenched in your sleep?
- Do you have, or have you ever had, pain in your jaw or the sides of your face (in and about the ears)?