

Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Preferred Phone \_\_\_\_\_ (C) (H) (W) Other Phone \_\_\_\_\_ (C) (H) (W)

Other Phone \_\_\_\_\_ (C) (H) (W) Email Address \_\_\_\_\_

Would you like appointment reminders via text \_\_\_\_\_ or email? \_\_\_\_\_ or phone? \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Date of your last Physical exam \_\_\_\_\_ SSN \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

**PHYSICAL HEALTH**

Known medical conditions \_\_\_\_\_

What medications are you taking? \_\_\_\_\_

Are you allergic to any medications? (antibiotics, aspirin, codeine, Novocain, etc.) \_\_\_\_\_

Are you aware of any **other** allergies? \_\_\_\_\_

Have you been hospitalized lately? \_\_\_\_\_

Do you smoke cigarettes? \_\_\_\_\_ # of packs per day \_\_\_\_\_ Chewing tobacco? \_\_\_\_\_

Have you ever been told that you **have** or **had** the following?

- |                             |                          |                              |                          |
|-----------------------------|--------------------------|------------------------------|--------------------------|
| chest pains                 | <input type="checkbox"/> | lung problems                | <input type="checkbox"/> |
| heart disease               | <input type="checkbox"/> | tuberculosis                 | <input type="checkbox"/> |
| rheumatic fever             | <input type="checkbox"/> | persistent cough             | <input type="checkbox"/> |
| congenital heart disease    | <input type="checkbox"/> | bruise easily                | <input type="checkbox"/> |
| heart murmur                | <input type="checkbox"/> | anemia                       | <input type="checkbox"/> |
| high or low blood pressure  | <input type="checkbox"/> | cancer or leukemia           | <input type="checkbox"/> |
| blood pressure _____        |                          | bleeding problems            | <input type="checkbox"/> |
| fainting spells             | <input type="checkbox"/> | stomach ulcers               | <input type="checkbox"/> |
| kidney problems             | <input type="checkbox"/> | sexually transmitted disease | <input type="checkbox"/> |
| stroke                      | <input type="checkbox"/> | sinus problems               | <input type="checkbox"/> |
| hormonal problems (thyroid) | <input type="checkbox"/> | artificial joints            | <input type="checkbox"/> |
| diabetes                    | <input type="checkbox"/> | prosthetic valves            | <input type="checkbox"/> |
| liver problems (jaundice)   | <input type="checkbox"/> |                              |                          |
| hepatitis                   |                          |                              | <input type="checkbox"/> |

**Please turn over and complete the other side**

## DENTAL HEALTH

Are you happy with your smile? \_\_\_\_\_ If not, what would you change? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_ How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

Have you ever had any serious problem associated with dental treatment in the past? \_\_\_\_\_

Do you have any pressing dental concerns? \_\_\_\_\_

Do you have a dry mouth or burning tongue? \_\_\_\_\_

Do your gums bleed, or feel tender or swollen? \_\_\_\_\_

Are your teeth sensitive to hot  cold  sweets   
or do they hurt while chewing  ?

Do you use a hard  medium  or soft  toothbrush?

Do you clench or grind your teeth? \_\_\_\_\_

Have you ever had local anesthetic (Novocain)? \_\_\_\_\_

Do you wear full  or partial  dentures? \_\_\_\_\_

Do you gag easily? \_\_\_\_\_

Are you nervous about dental treatment? \_\_\_\_\_

Have you had or are you undergoing orthodontic treatment? \_\_\_\_\_

Do you have any habits such as nail biting  thumb-sucking   
pencil chewing  cheek biting  others? \_\_\_\_\_

### **CONSENT:**

The undersigned hereby authorizes the dentist to perform all necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's dental or oral-facial needs including x-rays, study models, photographs, medications and use of local anesthetic agents.

The undersigned also acknowledges that the above questions concerning the medical (physical) and dental history have been correctly answered to the best of their knowledge.

\_\_\_\_\_  
Patient signature (or parent of minor) date \_\_\_\_\_

\_\_\_\_\_  
Dentist signature date \_\_\_\_\_