

Patient Information

Patient Name _____ Date _____

Patient Address _____

Sex: ___M ___F Age _____ Birthdate _____ SS# _____
City State Zip

___ Single ___ Married ___ Widowed ___ Separated ___ Divorced

School/Employer _____ Spouse's Name _____

Whom may we thank for referring you? _____

Phone Numbers

Home (____) _____ Work (____) _____ Ext _____ Cell (____) _____

Mother's Work (____) _____ Father's Work (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone not living in your household.)

Name _____ Relationship to Patient _____

Home Phone (____) _____ Work Phone (____) _____

Dental Insurance/ Responsible Party

Who is responsible for this account? _____

If insured, Subscriber's Name _____ Relationship to Patient _____

Address (If different from Patient) _____
City State Zip

Birthdate _____ SS# _____ Employer _____

Insurance Company _____ Group # _____

Dental History

Reason for today's visit _____

Current Dentist _____ City/State _____ Phone Number _____

Date of last dental visit _____ Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between	
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	the teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sores or growths in your mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette, pipe, or cigar		Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
How often do you floss? _____		How often do you brush? _____	

Health History

Physicians Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionamin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis,		Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart		Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with		Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No

Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen feet or ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen neck glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor/growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Weight loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No Due Date _____ Are you nursing? Yes No
 Taking birth control pills? Yes No

Medications

List any medications you are currently taking and the correlating diagnosis: _____

Pharmacy Name _____ Phone _____

Allergies

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local anesthetics
<input type="checkbox"/> Barbituates	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____