INITIAL PATIENT INFORMATION AND HEALTH HISTORY

PATIENT INFO:

NAME ______________________ BIRTHDATE ______________

(CIRCLE ONE) CHIILD SINGLE MARRIED WIDOWED DIVORCED REFERRED BY: ______________

HOME ADDRESS ______________________ HOME PHONE ______________

CITY/ZIP ______________________ CELL PHONE ______________

WORK PHONE ______________

INSURANCE INFO:

RESPONSIBLE PARTY ______________________ D.O.B. ______________

RELATIONSHIP ______________________ CELL PHONE ______________

EMPLOYER ______________________ WORK PHONE ______________

INSURANCE ______________________ SS # ______________

PATIENT DENTAL HISTORY

	(circle)
1. Do your gums bleed while brushing or flossing?	Y N
2 .Are your teeth sensitive to hot/cold/sweets?	Y N
3. Are your teeth sensitive to pressure?	Y N
4. Do you feel pain in any of your teeth?	Y N
5. Do you have any loose teeth?	Y N
6. Do you have any sores or lumps in your mouth?	Y N
7. Have you had any head,neck,or jaw injuries?	Y N
8. Have you ever experienced any of the following problems in your jaw?	
A) Clicking?	Y N
B) Pain (joint,ear,side of face)?	Y N
C) Difficulty opening or closing?	Y N
D) Difficulty in chewing?	Y N

	(circle)
9. Do you have frequent headaches?	Y N
10. Do you clench or grind your teeth?	Y N
11. Do you bite your lips or cheeks frequently?	Y N
12. Have you ever had any difficult extractions?	Y N
13. Have you had periodontal work?	Y N
14. Have you had orthodontal work?	Y N
15. Have you ever had prolonged bleeding?	Y N
16. Have you ever had instruction on the	
- Correct method of brushing your teeth?	Y N
- Correct method of brushing your gums?	Y N
- Correct method of flossing your teeth?	Y N
- Frequency of brushing?	Y N
- Frequency of flossing?	Y N

WHY ARE YOU HERE TODAY? ______________________________________

DATE OF LAST DENTAL EXAM ______________ PREVIOUS MAJOR DENTAL TREATMENT? **Y N**

PATIENT MEDICAL HISTORY

Physician ______________________ Office Phone ______________________

1. Are you under medical treatment now? ______________________
2. Have you ever been hospitalized? ______________________
3. Do you use tobacco, alcohol, cocaine, or other drugs? ______________________
4. Are you wearing contact lenses? Yes ________ No ________
5. List any medications you are currently taking: ______________________.
6. WOMEN ONLY: Are you nursing, taking birth control pills, pregnant or think you might be pregnant? (please circle)
7. Are you allergic to or have you had any reactions to the following: (please circle)
   Local anesthetics (e.g. novocaine), penicillin/other anti-biotics, sulfa drugs, iodine, latex
8. Please list ANY allergies that you have: ______________________.

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