



PERSONAL HISTORY

Welcome to Our Office

Name: _____ Birthdate: _____ Age: _____
M / D / Y

Mailing Address: _____

Please describe the reason for your visit today: _____

How or who referred you to our office? _____

Phone: Work: _____ Home: _____ Cell: _____

Email: _____ Preferred Contact: W / H / C / EM

In case of emergency notify _____ Relationship _____ Phone: _____

Insurance Co. Name _____ Policy # _____ ID# _____

Occupation: _____ Employer: _____

Person responsible for account (if other than yourself): Name: _____

Family Physician: _____ Phone: _____

Health History: Please check if you gave or had any of the following

<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you in good health?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Condition
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your health changes in the past year	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pain, shortness of breath, Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexual Transmitted Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic (Scarlet) Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive/Aids
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Cancer
<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment, Chemotherapy
<input type="checkbox"/> Yes <input type="checkbox"/> No	High/Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease, Hepatitis (A,B,C)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Heart Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Organ Transplant
<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head/Neck Injuries
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches
<input type="checkbox"/> Yes <input type="checkbox"/> No	TB, Asthma or Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions/Epilepsy
<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Breathing Lying Down	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness/Fainting
<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis/Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care
<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant: Month _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recreational Drugs/Alcohol
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hyper/Hypo Glycemia		

List any and all Allergies _____

List any and all Drug/medications you are taking & for what condition: _____

List any and all surgeries: _____

Do you use any tobacco products? Type/Frequency: _____

Are you being treated by a doctor now? Who? _____

The above information is true and correct to the best of my knowledge: _____

Patient Signature: _____ Date: _____



GETTING TO KNOW YOU

Name: _____ Date: _____

What name would you like us to call you: _____

Please describe the reason for your visit today: _____

How long has this been going on and what other events apply to today's visit:

Why have you decided to deal with this now?

Have you consulted with any other dentist this Yes No If yes, what was discussed or done?

When was your last dental check up, cleaning and xrays? _____

Who is your regular or previous dentist? _____

Have you noticed or has any dentist or hygienist ever mentioned that you:

Gum Disease (Gingivitis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding/Sore Gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitive to Hot/Cold/Sweet/Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bad Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food Catches Between Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grind or Clench Your Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	PAST TRETMENT	
Clicking or Popping Jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gum Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Jaw Pain or Tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Root Canal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty Opening/Closing Jay	<input type="checkbox"/> Yes <input type="checkbox"/> No	Oral Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Wisdom Teeth <input type="checkbox"/> Jawbone/Joint <input type="checkbox"/> Dental Implant	
Oral Habits	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bite Plate	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Biting Fingernails <input type="checkbox"/> Chew Pen/Pencil <input type="checkbox"/> Biting Cheek/Lip		Bite Adjustment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loose Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Would you like to know your options to: Improve your smile look younger Keep your teeth Whiter Teeth

Patient Release: I certify that I have provided an accurate and complete medical and dental history for myself (or my dependents) and have not omitted ant information. I authorize the dentist to perform diagnostic procedures and provide treatments as required for my (or my dependents) dental care. I authorize the dentist to consult with my physician (or specialist) regarding any compromising medical condition in my (or my dependents) medical/dental history. I will inform the dental the dental office of any changes in my health status.

Date: _____ Signature : _____ Reviewed by: _____

Patient Parent Guardian Treating Dentist/Hygenist _____