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

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

List any and all Allergies ______________________

List any and all Drug/medications you are talking & 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: __________

CLINIC SUMMERY

GETTING TO KNOW YOU

Name: ______________________ Date: ____________

What name would you like us to call you: ______________________

Please describe the reason for your visit today: ______________________

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____

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