



Today's Date: \_\_\_/\_\_\_/\_\_\_

**Patient Information**

Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male  Female   
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (Mobile) \_\_\_\_\_ (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_

Parent/Guardian Information (If Patient is a minor)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (Mobile) \_\_\_\_\_ (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
Email Address \_\_\_\_\_

**Insurance Information**

Primary Insurance	Secondary Insurance
Policy Holder Name _____	Policy Holder Name _____
Date of Birth _____	Date of Birth _____
Relationship to Patient Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Relationship to Patient Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____
Insurance Company _____	Insurance Company _____
Member ID _____	Member ID _____
Group Number _____	Group Number _____
Employer _____	Employer _____
Insurance Phone Number _____	Insurance Phone Number _____

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Consent for Initial Exam**

I consent to the diagnostic procedures necessary to perform an Initial Exam, which may include any necessary radiographs, intra-oral/extra-oral exam.

Signature (responsible party if patient is a minor) \_\_\_\_\_ Date \_\_\_\_\_

**Dental History**

Reason for Today's Visit \_\_\_\_\_

Are you currently experiencing dental pain or discomfort? Yes  No  (If yes, Where) \_\_\_\_\_

Are there any other concerns we should be aware of? \_\_\_\_\_

When did you last visit a Dentist? \_\_\_\_\_

	Yes	No	Don't Know
Do your gums bleed when you brush or floss?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your Mouth Dry?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear Dentures or Partials?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How do you feel about your smile? \_\_\_\_\_

Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Patient Medical History**

Are you under the care of a Physician now? Yes  No  Physician's name \_\_\_\_\_

Have you every been hospitalized or had a major operation/surgery? Yes  No

If yes, Please Explain \_\_\_\_\_

Have you every had a serious head or neck injury? Yes  No  If yes, Please Explain \_\_\_\_\_

**Please list any medications that you are currently taking**

Medication	Dosage	How Often	Route (Oral / Injection etc)

Do you use tobacco? (smoking, snuff, chew, bidis) Yes  No

Do you drink Alcoholic beverages? Yes  No  If yes, about how many drinks per week? \_\_\_\_\_

Do you use controlled substances? Yes  No

**Are you Allergic to any of the following?** Latex  Local Anesthetic  Penicillin  Aspirin  Codeine  Metal   
 Sulfa Drugs  Acrylic  Other \_\_\_\_\_

**Women Only-** Are you Pregnant? Yes  No  Number of weeks \_\_\_\_\_ Nursing? Yes  No  Taking birth control pills? Yes  No

**Medical History - Do you have or have you had any of the following?**

- |                              |  |                           |  |   |  |
|------------------------------|--|---------------------------|--|---|--|
| Artificial Heart Valve       | Yes <input type="checkbox"/> No <input type="checkbox"/> | Dizzy / Fainting Spells   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Psychiatric Care                            | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Artificial Joints            | Yes <input type="checkbox"/> No <input type="checkbox"/> | Down Syndrome             | Yes <input type="checkbox"/> No <input type="checkbox"/> | Rheumatic Fever                             | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| AIDS / HIV                   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Emphysema                 | Yes <input type="checkbox"/> No <input type="checkbox"/> | Scarlet Fever                               | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Anemia                       | Yes <input type="checkbox"/> No <input type="checkbox"/> | Epilepsy / Seizures       | Yes <input type="checkbox"/> No <input type="checkbox"/> | Shortness of Breath                         | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Angina / Chest Pains         | Yes <input type="checkbox"/> No <input type="checkbox"/> | Frequent Cough            | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sickle Cell Anemia                          | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Arthritis, Rheumatism        | Yes <input type="checkbox"/> No <input type="checkbox"/> | Glaucoma                  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sinus Trouble                               | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Asthma                       | Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Attack / Failure    | Yes <input type="checkbox"/> No <input type="checkbox"/> | Skin Rash                                   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| - (required hospitalization) | Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Disease             | Yes <input type="checkbox"/> No <input type="checkbox"/> | Stroke                                      | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Autism                       | Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Murmur              | Yes <input type="checkbox"/> No <input type="checkbox"/> | Swelling of feet or ankles                  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Bleeding / Clotting Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Valve Prolapse      | Yes <input type="checkbox"/> No <input type="checkbox"/> | Thyroid Problems                            | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Blood Disorder               | Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Pacemaker           | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tonsillitis                                 | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Birth Defect                 | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hepatitis (type _____ )   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tuberculosis                                | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Bronchitis                   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Herpes                    | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tumor/ growth (head/neck)                   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cancer                       | Yes <input type="checkbox"/> No <input type="checkbox"/> | High Blood Pressure       | Yes <input type="checkbox"/> No <input type="checkbox"/> | Ulcers                                      | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cerebral Palsy               | Yes <input type="checkbox"/> No <input type="checkbox"/> | High Cholesterol          | Yes <input type="checkbox"/> No <input type="checkbox"/> | Unexplained weight loss                     | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Chemo / Radiation Therapy    | Yes <input type="checkbox"/> No <input type="checkbox"/> | Immune Deficiency         | Yes <input type="checkbox"/> No <input type="checkbox"/> | Any other serious illness not listed above? | _____  |
| Cold Sores / Fever Blisters  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Jaundice                  | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____                                       | _____  |
| Congenital Heart Disorder    | Yes <input type="checkbox"/> No <input type="checkbox"/> | Kidney Disease            | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____                                       | _____  |
| Convulsions                  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Low Blood Pressure        | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____                                       | _____  |
| Diabetes                     | Yes <input type="checkbox"/> No <input type="checkbox"/> | Osteoporosis / Osteopenia | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____                                       | _____  |

The Information I have given is correct to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes in my/my child's health and/or medications. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me/my child. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 (Parent / Legal Guardian if Patient is a minor)