



Personal Information

Name: _____ Date of Birth _____
Primary Phone: _____ Secondary Phone _____
Email Address: _____
Home Address (City, State, Zip): _____
Emergency Contact (Name and Number): _____

Insurance Information

Employed By: _____ Dental Insurance Company: _____
Insurance Member ID Number: _____ Your SSN: _____
Are you the policyholder? Yes No If not, who? _____
Policy Holder DOB: _____ Policy Holder SSN: _____

Dental History

When was your last dental visit? _____
Is Your Dental Health Important? Not Important Somewhat Important Very Important
What is Your Main Reason for Your Visit here today? _____

- Do You Have Tooth Pain/Sensitivity? Yes No
- Do You Have Any Broken/Chipped Teeth? Yes No
- Do You Experience Jaw Pain? Yes No
- Do Your Gums Ever Bleed? Yes No
- Have You Used Tooth Whitening Products? Yes No
- Have You Ever Had Braces? Yes No
- Have You Ever Had a 'Root Canal'? Yes No
- Are You Missing Any Teeth? Yes No
- Do You Wear a Dental Night Guard? Yes No
- Do You Experience Dry Mouth? Yes No
- Do You Use Fluoride Mouth Rinse? Yes No
- Have You Ever Had Gum (Periodontal) Treatments? Yes No
- Does Anyone in Your Family Wear Dentures? Yes No
- Do You Require Antibiotics Before Dental Treatment? Yes No
- Ever had a Serious Problem with Previous Dental Work? Yes No
- You Drink Soda Pop and/or Energy Drinks Never Sometimes Frequently
- You Drink Coffee and/or Tea Never Sometimes Often
- Your Favorite Snack is? _____

How Often Do You Brush your Teeth? _____ Floss? _____

How Did You Hear About Our Dental Practice? _____

What is the MOST important thing you are looking for in your dentist and dental office? _____

Your Smile Comes First!

Affordable, Kind, and Convenient

Health History

Are You Currently Under Care of a Physician? Yes No

Where Do You Go For Medical Care? _____ Most Recent Visit? _____

Height? _____ Weight? _____

Do you use Tobacco in any form? Yes No How many years have you used? _____

Allergies

Do You Have any Allergies or "Bad Reactions" to the Following?

Penicillin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Latex	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clindamycin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Metals	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Erythromycin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, describe details of your reaction: _____

Conditions

Do You Currently Have Any of the Following?

Alzheimer's	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Endocarditis History	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina Pectoris	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Attack History	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Surgery History	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis A, B, or C	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Acid Reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint Replacement History	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dialysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty Breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficult Seeing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pregnant/Nursing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty Hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Active STD or STI	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Abuse History	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke History	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Explain Details: _____

Medications

Please List the Medications you Regularly Take:

Have You Ever Taken any Bisphosphonate drugs, such as Fosamax or Zoledronate? Yes No
Anything Else You Would Like us to Know Regarding Your Health Status?

Thank You!

Patient Signature

Date