# Welcome to our practice!

**Please fill out these forms completely. The better we commucate, the better we can better care for you. Our goal is to help you achieve and maintain maximum oral health.**

## Patient Information

Name_____ Date_____

Name you prefer to be called_____ Gender____ DOB_____ Age_____

Address_____City_____State_____Zip_____

Social Security#_____ Single___ Married___ Partnered___ Divorced___ Widowed___

Home Phone _____ Cell Phone_____

Business Phone_____ E-mail _____

Occupation_____ Interests, sports, hobbies_____

Who may we thank for referring you to us? _____

## Dental History

Date of Last Dental Examination _____ Previous Dentist_____

Reason for Today's Visit _____

| **Please indicate any history of the following:** | Y | N |
|---|---|---|
| Have you had any serious problems associated with dental treatment? | | |
| Have you had serious injury to your face, head or teeth? | | |
| Are you currently experiencing pain in any part of your mouth? | | |
| Are any of your teeth sensitive to hot, cold, sweets? | | |
| Do your gums bleed when you brush? | | |
| Do you have any loose or broken fillings? | | |
| Do you have any loose or broken teeth? | | |
| Do you clench or grind your teeth? | | |
| Does your jaw click or pop? | | |
| Have you ever had TMJ (jaw joint) problems? | | |
| Do you experience bad breath? | | |
| Does food collect between your teeth? | | |
| Do you gag easily? | | |
| Do you feel your teeth could be whiter? | | |
| Do you snore, choke or have episodes of not breathing while you sleep? | | |
| Do you frequently experience unrefreshing sleep? | | |
| Do you feel nervous or anxious about having dental treatment? | | |

Please let us know if there is anything you would like to change about your smile: _____

Please share with us anything that will make you more comfortable during your visit: _____

**Medical History**

General Health: Excellent ___ Good___ Fair___ Poor___ Date of Last Physical Exam_____

Physician's Name_____ Phone_____

Address_____

Have you been admitted to a hospital or needed emergency care during the past two years? Y__ N __ If yes, Please explain_____

Are you currently under the care of a physician? Y__ N__ Explain, if so _____

If you are currently using any medications or supplements, please list each one and the amount taken each day and reason for each:

_____

Have you ever been on a Bisphosphinate Medication ex: Fosamax, Boniva, Aconel,Atelvia, Didronel? ___

Have you ever taken Phen-Fen or Redux? _____

Are you on a special diet? _____ Explain, if so_____

Are you allergic to any of the following: Penicillin__ Tetracycline__ Sulfa Drugs__ Aspirin__ Codeine__

Dental Anesthetics__ Latex__ Metals ___ Other_____

| **Please indicate any history of the following:** | Y | N |
|---|---|---|
| Blood Pressure High Low | | |
| Heart problems Please explain: | | |
| Artificial Heart Valve | | |
| Pacemaker | | |
| Implanted Defibrillator | | |
| Bleeding disorder or Prolonged bleeding from extractions, surgery or trauma | | |
| Arthritis | | |
| Artificial Joints, Pins, etc. | | |
| Diabetes | | |
| Anemia | | |
| Stroke | | |
| Dizziness or Fainting | | |
| Headaches | | |
| Epilepsy, Seizures or Convulsions | | |
| Lyme Disease | | |
| Cancer or Malignancy | | |
| Benign Tumors or Growths | | |
| Radiation or Chemotherapy | | |
| Gastrointestinal Disorders or Ulcers | | |
| Kidney Disease | | |
| Liver Disease or Hepatitis | | |
| Thyroid Disease | | |

| | Y | N |
|---|---|---|
| Renal Disease | | |
| Hay fever, Asthma, or Breathing Problems | | |
| Sinus Problems | | |
| Respiratory Disease or Disorder | | |
| Glaucoma | | |
| Vision Problems | | |
| Hearing Loss | | |
| Drug Addiction | | |
| AIDS or HIV | | |
| Venereal Disease | | |
| Herpes | | |
| Eating Disorder | | |
| Do You Smoke or Vape? | | |
| Do you Use Chewing Tobacco? | | |
| Do You Use Controlled Substances? | | |
| Women only: Are you pregnant? If yes, what month? _____ | | |
| Trying to get pregnant? | | |
| Nursing? | | |
| Are you taking birth control pills? | | |
| Men only: Are you currently taking Nitrates, Viagra, Cialis? | | |

To the best of my knowledge, all of the preceding answers and information provided are true.

If I ever have any change in my health, I will inform the doctors at my next appointment.

Patient Signature_____ Date_____