Date:_____

Name:_____Birth Date:_____Marital Status:_____

Address:_____City:_____State:_____Zip:_____

Telephone:_____Cell Phone:_____Email Address:_____

Employer:_____ Social Security Number: _____

Employer's Address:_____Driver's License:_____

Name of Spouse /Parent / Guardian:_____Occupation S /P / G:_____

Employed By:_____Social Security Number:_____

Do You Have Dental Insurance? Yes / No Insurance Company:_____

Your Dentist:_____How long have you been a patient there?:_____

Your Physician:_____Phone:_____

Who may we thank for your referral?_____Reason for referral?_____

MEDICAL / HEALTH HISTORY

Date of Last Physical Exam:_____

Are you presently under a Physician's Care? Yes / No

Have you been hospitalized in the last 3 years? Yes / No

For what condition?_____

Does any of the following apply to you?

	YES	NO
1. Hepatitis, jaundice or liver disease?.....		
2. Heart:.....		
a. Rheumatic Fever.....		
b. Heart Murmur.....		
c. Heart Trouble or Stroke.....		
d. High Blood Pressure.....		
e. Chest Pains.....		
f. Stroke.....		
3. Allergies:		
a. Drug Allergies?.....		
If Yes to what?_____		
b. Asthma, hay fever, sinus issues or allergies.		
4. Epilepsy or seizures.....		
5. Diabetes.....		
a. Average blood sugar reading_____		
b. Last A1C Score:_____		
6. Arthritis or rheumatism.....		
7. Have you had a joint replaced?		
a. Which joint (s)?_____		
b. When?_____		
8. Stomach or duodenal ulcers.....		
9. Kidney disease or infection.....		
10. Have you ever tested positive for HIV or AIDS?.....		
11. Venereal disease.....		
12. Medical X-Ray treatments.....		

	YES	NO
13. Glaucoma.....		
14. Abnormal Bleeding problems or disorders.....		
a. Prolonged bleeding following tooth extraction..		
b. Anemia.....		
C. Clotting problems.....		
d. Other Blood Problems.....		
15. Medications:		
a. Do you take any drugs or medications?.....		
List Medications:_____		
_____		
b. Do you take blood thinners?		
List Blood Thinners? _____		
c. Do you require pre-medication prior to having dental work done?.....		
16. Do you take or have you ever taken any bisphosphonates used to treat osteoporosis? (e.g. Boniva, Fossamax).....		
17. Are you a nervous person?.....		
If yes, do you take medications for this illness?.....		
18. Do you wear contact lenses?.....		
19. Have you had any other serious illnesses we should know about?.....		
If yes what?_____		
20. Do you smoke?.....		
If Yes how much?_____		
Women:		
21. Are you pregnant or trying to get pregnant?.....		
22. Do you take birth control pills?.....		
23. Are you presently in or are you post-menopausal.....		

DENTAL HISTORY

	YES	NO
1. Have you ever had periodontal treatment?.....		
2. Do your gums bleed?.....		
3. Do you grind your teeth day or night?.....		
4. Do you clench your teeth day or night?.....		
5. Do you have sore, sensitive teeth?.....		
6. Do you have pain in your jaw joint area?.....		
7. Do you notice clicking in your jaw?.....		

	YES	NO
8. Have you ever had dental implants?.....		
9. Do you have pain elsewhere in your face or jaws?.....		
10. Have you ever had your teeth straightened?.....		
(Orthodontics) If yes when:_____		
11. Circle the devices used in your oral care: floss, toothpicks, water irrigation, electric toothbrush, other.		
12. Estimated date of your last cleaning:_____		

Present Dental Complaints:_____Signature:_____

WITH YOUR PERMISSION WE WILL SEND TEXT MESSAGES AND/OR EMAILS IN ADDITION TO CALLS TO CONFIRM OR TO NOTIFY YOU IF NEEDED. I WOULD LIKE TO: OPT IN / OPT OUT PREFERRED CELL NUMBER: _____