



Welcome TO OUR PRACTICE

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____
SS # _____
Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
If Patient is a Student, Name of School/College _____ City _____ State _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____
Address _____
Date of last dental visit _____ Date of last dental X-rays _____
Check (✓) if you have had any of the following:
 Bad breath Grinding teeth Sensitivity to heat
 Bleeding gums Loose teeth or broken fillings Sensitivity to sweets
 Clicking or popping jaw Periodontal treatment Sensitivity when biting
 Food collection between the teeth Sensitivity to cold Sores or growths in your mouth
How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____
Have you had any serious illnesses or operations? Yes No If yes, describe _____
Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____
(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No
Check (✓) if you have had any of the following:
 AIDS Cortisone Treatments Hepatitis Rheumatic Fever
 Anemia Cough, Persistent High Blood Pressure Scarlet Fever
 Arthritis, Rheumatism Cough up Blood HIV Positive Shortness of Breath
 Artificial Heart Valves Diabetes Jaw Pain Skin Rash
 Artificial Joints Epilepsy Kidney Disease Stroke
 Asthma Fainting Liver Disease Swelling of Feet or Ankles
 Back Problems Glaucoma Mitral Valve Prolapse Thyroid Problems
 Blood Disease Headaches Nervous Problems Tobacco Habit
 Cancer Heart Murmur Pacemaker Tonsillitis
 Chemical Dependency Heart Problems Psychiatric Care Tuberculosis
 Chemotherapy Describe _____ Radiation Treatment Ulcer
 Circulatory Problems Hemophilia Respiratory Disease Venereal Disease

MEDICATIONS ALLERGIES

List medications you are currently taking:

