PLEASE PRINT AND FILL OUT COMPLETELY

PATIENT'S NAME ______ ADDRESS ______ APT # ______

CITY ______ STATE ______ ZIP ______ HM# ______ WK# ______ DOB ______

PATIENT'S SSN ______ ______ ______ SEX ______ MARITAL STATUS ______ EMPLOYER ______ OCCUPATION ______

GUARDIAN (IF UNDER 18) ______ ADDRESS ______ APT # ______

CITY ______ STATE ______ ZIP ______ HM# ______ WK# ______ DOB ______

GUARDIAN'S SSN ______ ______ ______ SEX ______ MARITAL STATUS ______ EMPLOYER ______ OCCUPATION ______

SUBSCRIBER'S NAME ______ ADDRESS ______ APT # ______

CITY ______ STATE ______ ZIP ______ HM# ______ WK# ______ DOB ______

SUBSCRIBER'S SSN ______ ______ ______ SEX ______ MARITAL STATUS ______ EMPLOYER ______ OCCUPATION ______

INS. CO ______ PLAN NAME ______ INS. PH ______ RELATION TO PATIENT ______

CELL# ______ EMAIL ______ REFERRED BY ______

MEDICAL HISTORY – Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. **HAVE YOU EVER HAD OR HAVE:**

		YES	NO
1.	Asthma, hay fever, sinusitis, or other allergies		
2.	Allergy to penicillin, aspirin, local or general anesthetic, or other drugs; specify:		
3.	Blood pressure or heart problems / joint replacements		
4.	Rheumatic fever or heart murmur		
5.	A pacemaker or open heart surgery		
6.	Diabetes, liver, kidney, thyroid, or lung problems		
7.	Ulcers or stomach problems		
8.	Hepatitis or Jaundice		
9.	Epilepsy or nervous disorders		
10.	Bleeding or clotting disorders		
11.	Arthritis		
12.	Venereal Disease, Herpes		
13.	Acquired Immune Deficiency Syndrome (AIDS)		
14.	Any other illness		
15.	Do any wounds heal slowly or present complications?		
16.	Are you presently taking any medicine? Specify:		
17.	Are you presently under the care of a physician?		
18.	When was your last physical exam?		
19.	Have you ever been hospitalized? Date: Reason:		
20.	Have you had X-ray treatments or chemotherapy?		
21.	Are you presently on a diet?		
22.	Women ( ) Are you taking birth control pills? ( ) Are you pregnant?		

______ ______

PATIENT SIGNATURE DATE DOCTOR SIGNATURE DATE

DENTAL HISTORY

PATIENT'S NAME ______________________________

DATE OF LAST DENTAL EXAM ____________________

DATE OF LAST FULL MOUTH X-RAY ______________ WHERE TAKEN ____________________

		YES	NO
1.	Have you had trouble from previous dental care?		
2.	Do you have pain in your jaw or near your ears?		
3.	Do you have any unhealed injuries or inflamed areas in or around your mouth?		
4.	Have you experienced any growths or sore spots in your mouth?		
5.	Does any part of your mouth hurt when clenched?		
6.	Have you ever had Novocaine or other local anesthetic?		
7.	Have you ever had Nitrous Oxide (laughing gas)?		
8.	Have you ever had general anesthesia?		
9.	Have you ever had any reaction or allergic symptoms to Novocaine, local or general anesthetics?		
10.	Have you ever had any difficult extractions in the past?		
11.	Have you ever had prolonged bleeding following extractions in the past?		
12.	Do your gums bleed?		
13	Do you have a bad taste in your mouth or mouth odor?		
14.	Have you ever had instructions on the care of your gums?		
15.	Do you chew on only one side of your mouth? If so, why?		
16.	Do you habitually clench or grind your teeth during the night or day?		
17.	Is any part of your mouth sensitive to pressures or irritants (hot, cold or sweets)?		

Is there any other problem not covered above that you would like to discuss? ______________________________

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PATIENT SIGNATURE DATE DOCTOR SIGNATURE DATE