PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place in us to provide dental services. To assist us in serving you, please complete the following form. The information provided is important to your dental health. If there have been any changes in your health, please let us know. If you have any questions, please don't hesitate to ask.

Patient's name _____Preferred name _____Birth date (month/date/year)_____
If a minor, parents' names _____
Home phone _____ Work phone _____ Cell phone _____
Preferred Email Address
_____

Mailing address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Marital Status: ❑ Married ❑ Unmarried ❑ Divorced ❑ Widowed

Spouse's name _____ Spouse's employer _____

Emergency Contact (if other than spouse): _____Phone Number: _____

How did you hear about our office?
❑ Building Sign/Drove By ❑Website ❑Mailer ❑Event_____❑Employee_____
❑Review Site_____❑Current Patient-Whom may we thank? _____

About how long since your last dental appointment?_____ Reason for leaving previous dentist_____
Current dental concerns?
_____

Are your teeth: ❑Sensitive? ❑ Dissatisfied with appearance? ❑ Whiter teeth? ❑Interested in replacing mercury/amalgam/silver fillings?

Feelings regarding dental treatment? ❑Not at all anxious ❑ A little anxious ❑Anxious ❑Very anxious

MEDICAL HEALTH HISTORY

How would you rate your overall general health: ❑Excellent ❑Good ❑Fair ❑Poor Height _____Weight_____

Do you currently have, or have you previously had, any of the following medical conditions? (**Please check all that apply and explain below**)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, or heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke, vape, or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely, to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you currently taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)- Name_____
- ❑ Antibiotics or sulfa drugs- Name_____
- ❑ High blood pressure medicine- Name_____
- ❑ Antidepressants or tranquilizers- Name_____
- ❑ Insulin, Orinase, or other diabetes medications- Name_____
- ❑ Nitroglycerin or heart medication- Name_____
- ❑ Cortisone or other steroids- Name_____
- ❑ Osteoporosis (Fosomax, Skelid, Bonefos) medication Name_____
- ❑ Other:_____

please list ***ALL*** medications

Women Only:

- ❑ May be pregnant Expected delivery date: _____
- ❑ Nursing
- ❑ Taking hormones or contraceptives

Please explain the current status of any checked boxes:
_____
_____

Name of your current physician:_____ Phone Number: _____

Signature of patient (or guardian if patient is a minor) : _____ Date: _____