PERSONAL INFORMATION:

Patient Name:_____ Today's Date:_____
Home Address:_____ Date Of Birth: (D/M/Y)_____
_____
Postal Code:_____ Home Ph.#:_____
E-Mail:_____ Cell Ph. #:_____
Height:_____ Weight:_____ Work Ph. #:_____
Emergency Contact: (Name/Relationship)_____
Phone Number(s):_____
How did you find us: _____

MEDICAL HISTORY:

Name of Physician/and their specialty:_____

Date of last medical examination:_____ Purpose:_____

What is your estimate of your general health?: □Excellent □Good □Fair □Poor

Do You Have or Have You Ever Had: **(YES OR NO)**

	Y:	N:		Y:	N:
Glaucoma:			Osteoporosis/Osteopenia (i.e. Taking Bisphosphonates):		
Heart Problems			Alcohol / Drug Dependency:		
Heart Murmur:			Artificial Prosthesis (i.e. Heart Valve or Joints):		
Rheumatic Fever:			Tuberculosis:		
High Blood Pressure:			Breathing or Sleep Problems (i.e. Snoring, Sinus):		
Low Blood Presure:			Liver Disease:		
HIV/AIDS:			Arthritis:		
Tumor, Abnormal Growth:			Contact Lenses:		
Radiation Therapy:			Head Or Neck Injuries:		
Chemotherapy:			Epilepsy, Convulsions (Seizures):		
Venereal Disease:			Neurologic Problems:		
Are You Taking Blood Thinners:			A Stroke:		
Hepatitis:(Type: ____)			Viral Infections and Cold Sores:		
Anti-Depressant Medication:			Any Lumps or Swelling in the Mouth:		
Anemia or Blood Disorder:			Hives, Skin Rash, Hay Fever:		
Emphysema:			Kidney Disease:		
Asthma:			Thyroid or Parathyroid Disease:		
Hormone Deficiency			Jaundice:		
Diabetes:			High Cholesterol:		
Digestive Disorders(i.e. Gastric Reflux):			Stomach or Duodenal Ulcer:		
Are You Presently Being Treated For Any Other Illness?:			(FEMALE) Are You Taking Birth Control Pills?:		
Are You Subject To Frequent Headaches?:			(FEMALE) Are you pregnant?:		
Are You A Smoker Or Smoked Previously?:					

Are you Allergic Or Have You Ever Had An Allergic Reaction To:

□Aspirin, Ibuprofen, Acetaminophen
□Codeine
□Local Anesthetic
□Fluoride
□Metals (Titanium, Amalgam, Stainless Steel)
□Latex
□Penicillin
□Erythromycin
□Tetracycline
□Any Other Medications

Please List Any Medications, Vitamins, Herbal or Dietary Supplements Currently Taking **AND** What It Is For:

_____
_____
_____
_____
_____
_____
_____
_____
_____

DENTAL HISTORY:

What is your immediate concern?:_____

How would you rate the condition of your mouth?: ☐Excellent ☐Good ☐Fair ☐Poor

Are you fearful of dental treatment?: ☐YES ☐NO Scale of 1 (None) to 10 (Very):_____

Have you had an unfavorable dental experience?: ☐YES ☐NO
Details:_____

Have you ever had complications from past dental treatment?: ☐YES ☐NO
Details:_____

Have you ever had trouble getting numb or reactions to local anesthetic?: ☐YES ☐NO

Did you ever have braces, orthodontic treatment or had your bite adjusted?: ☐YES ☐NO

Do you / would you have any problems chewing gum?: ☐YES ☐NO

Do you / would you have any problems chewing bagels or other hard foods?: ☐YES ☐NO

Have your teeth changed in the last 5 years, become shorter, thinner or worn?: ☐YES ☐NO

Are your teeth crowding or developing spaces?: ☐YES ☐NO

Do you have any problems with sleep or wake up with an awareness of your teeth?: ☐YES ☐NO

Any problems with your jaw joint?: (Pain, Sounds, Limited Opening, Locking, Popping) ☐YES ☐NO

Do you have tension headaches or sore teeth?: ☐YES ☐NO

Do you wear or have you ever worn a bite appliance?: ☐YES ☐NO

Are any teeth sensitive to hot, cold, biting or sweets?: ☐YES ☐NO

Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?: ☐YES ☐NO

Have you ever been diagnosed or treated for periodontal (gum) disease?: ☐YES ☐NO

Have you ever experienced gum recession?: ☐YES ☐NO

Do your gums bleed when brushing, flossing or eating?: ☐YES ☐NO

Are your teeth becoming loose?: ☐YES ☐NO

Have you ever noticed an unpleasant taste or odor in your mouth?: ☐YES ☐NO

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE:_____ DATE: _____