Date ____________________

How did you first find out about our office? (circle one)

personal referral ______________________________ (name) location advertisement yellow pages internet other

Patient Information

Patient's Name ____________________ (last) ____________________ (first) ____________________ (middle)

Address ____________________ (street) ____________________ (city) __________ (state) __________ (zip)

Phone ______________ (home) ______________ (work) ______________ (cell) Social Sec. # ____________________

Birthdate ______________ E-mail ______________________________

Employer ______________________________ Dental Insurance ______________________________

Responsible Party Information

☐ Same as patient

Name ____________________ (last) ____________________ (first) ____________________ (middle)

Address ____________________ (street) ____________________ (city) __________ (state) __________ (zip)

Phone ______________ (home) ______________ (work) ______________ (cell) Social Sec. # ____________________

Birthdate ______________ E-mail ______________________________ Relation to patient ____________________

Medical History

Have you ever had any of the following problems? Please circle all that apply.

Y N Heart Disease
Y N High / low blood pressure
Y N Heart murmur
Y N Mitral valve prolapse
Y N Rhuematic fever
Y N Stroke
Y N Anemia
Y N Abnormal bleeding
Y N Diabetes
Y N Tuberculosis

Y N Asthma
Y N Hayfever/allergies
Y N Sinus problems
Y N Allergies to anesthetic
Y N HIV / AIDS
Y N Hip or knee replacement
Y N Kidney or bladder disease
Y N Gall bladder disease
Y N Thyroid disease
Y N Hepatitis / liver disease
Y N Dry Mouth

Y N Seizure / epilepsy
Y N Arthritis
Y N Ulcers
Y N Tonsilitis
Y N Cancer / radiation or chemotherapy
Y N Psychiatric care
Y N Drug / alcohol addiction
Y N Eye disorder
Y N Sexually transmitted disease
Y N Current pregnancy

Are you being treated by a physician? Y N If yes, for what? ______________________________

Physician's name ______________________________ Phone ____________________

List all current medications ______________________________

cont'd Medical History

Are you allergic to the following:

Y N Penicillin   Y N Aspirin   Y N Anesthetic

Y N Erythromycin   Y N Codeine   Y N Latex

List any other allergies ____

Is there anything else about your medical history you feel we should know? ____

____

Emergency Contact: ____________________ ____________________ ____________________
name relation phone

Dental Health

Is there anything you feel we should know about any past dental treatment? ____

____

Is there anything your previous dental office did that you want us to do? ____

Is there anything you didn't like? ____

To make our patients comfortable we offer several amenities. Circle all that you would like.

nitrous oxide (laughing gas)   music (type of music or artists) ____

neck pillow   blanket   lip balm   prescription medication

Smile Analysis

Are you unhappy with the overall appearance of your teeth, your smile? ☐ YES ☐ NO

Do you consider your teeth discolored, yellow or dark? ☐ YES ☐ NO

Would you like your teeth to be whiter? ☐ YES ☐ NO

Do you have any existing dental work you find unattractive? ☐ YES ☐ NO

If possible, what changes would you make to your smile? ____

____

The above information is correct to the best of my knowledge and I authorize the doctor and staff to provide dental services including photographic documentation for scientific and educational purposes. I assume responsibility for fees associated with all services provided.

Signature (Parent's signature if minor) ____