In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think I should have. Thank you for your cooperation.

DATE _____ SOCIAL SECURITY NO. _____

NAME _____ (Last) _____ (First) _____ (Middle)

ADDRESS _____ STREET _____ CITY _____ ZIP CODE _____ HOME PHONE _____

EMPLOYER NAME & ADDRESS _____ BUS. PHONE _____

DATE OF BIRTH _____ SEX _____ HEIGHT _____ WEIGHT _____ OCCUPATION _____

S M D W
MARITAL STATUS _____ SPOUSE'S NAME _____ REFERRED BY _____

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICE.

INS. CO. NAME _____ POLICY # _____

SECONDARY INS. CO. _____ POLICY # _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES. DEFINITE ARRANGEMENTS MUST BE MADE BEFORE TREATMENT BEGINS.

DATE _____ SIGNATURE _____

MEDICAL HEALTH

General health (please check): EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

Name and address of physician _____

_____

Last complete physical? _____

Are you taking any medication now? Yes ☐ No ☐ For what purpose? _____

Have you ever been treated for:

Heart disease	Yes ☐	No ☐	Heart murmur	Yes ☐	No ☐
Rheumatic fever	Yes ☐	No ☐	Jaundice	Yes ☐	No ☐
Abnormal blood pressure	Yes ☐	No ☐	Asthma or hay fever	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐	Sinus trouble	Yes ☐	No ☐
Tuberculosis or lung disease	Yes ☐	No ☐	Cough	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Congenital heart lesions	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐
H.I.V. Positive	Yes ☐	No ☐			

Are you allergic to: Penicillin ☐ Codeine ☐ Local injected anethestics ☐ Other medications ☐ _____

Are you subject to prolonged bleeding? Yes ☐ No ☐

Are you subject to fainting spells? Yes ☐ No ☐

Do you have excessive urination and/or thirst? Yes ☐ No ☐

(women)

Are you pregnant? Yes ☐ No ☐ How long? _____

Reason for visit _____

When was your last dental visit? _____

Have you ever had any serious problem associated with previous dental treatment? ..... Yes ☐ No ☐

If so, explain: _____

_____

How often do you brush your teeth? _____

What texture brush do you use? SOFT ☐ MEDIUM ☐ HARD ☐ NYLON ☐ NATURAL ☐

How often do you floss? _____

Do your gums bleed while brushing? ..... Yes ☐ No ☐

Do your gums bleed when flossing? ..... Yes ☐ No ☐

Do you avoid brushing any part of your mouth because of pain? ..... Yes ☐ No ☐

If yes, what part? _____

Do you feel twinges of pain when your teeth come in contact with:

a) hot foods or liquids, *i.e.*, soup, coffee, tea, etc.? ..... Yes ☐ No ☐

b) cold foods or liquids, *i.e.*, ice cream, cold fruit, etc.? ..... Yes ☐ No ☐

c) sweets, *i.e.*, candy, fruit, sweet desserts, etc.? ..... Yes ☐ No ☐

d) sours, *i.e.*, lemons, limes, grapefruit, etc.? ..... Yes ☐ No ☐

Do you feel pain to any of your teeth when brushing or flossing them? ..... Yes ☐ No ☐

Do you chew on only one side of your mouth? ..... Yes ☐ No ☐

If yes, explain: _____

_____

Do your gums feel tender or swollen? ..... Yes ☐ No ☐

Do you clench or grind your jaws while sleeping or during the day? ..... Yes ☐ No ☐

Do your jaws ever feel tired? ..... Yes ☐ No ☐

Do you wear dentures? ..... Yes ☐ No ☐

Do you usually have many cavities? ..... Yes ☐ No ☐

Do you lose fillings or break fillings? ..... Yes ☐ No ☐

Do you gag easily? ..... Yes ☐ No ☐

Are you familiar with the term "preventive dentistry"? ..... Yes ☐ No ☐

Please add anything you feel is important: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Patient signature)