INITIAL PATIENT INFORMATION AND HEALTH HISTORY

PATIENT INFO:

NAME _____ BIRTHDATE _____

(CIRCLE ONE) CHIILD SINGLE MARRIED WIDOWED DIVORCED REFERRED BY: _____

HOME ADDRESS _____ HOME PHONE _____

CITY/ZIP _____ CELL PHONE _____

WORK PHONE _____

INSURANCE INFO:

RESPONSIBLE PARTY _____ D.O.B. _____

RELATIONSHIP _____ CELL PHONE _____

EMPLOYER _____ WORK PHONE _____

INSURANCE _____ SS # _____

PATIENT DENTAL HISTORY

	(circle)		(circle)
1. Do your gums bleed while brushing or flossing?	Y N	9. Do you have frequent headaches?	Y N
2 .Are your teeth sensitive to hot/cold/sweets?	Y N	10. Do you clench or grind your teeth?	Y N
3. Are your teeth sensitive to pressure?	Y N	11. Do you bite your lips or cheeks frequently?	Y N
4. Do you feel pain in any of your teeth?	Y N	12. Have you ever had any difficult extractions?	Y N
5. Do you have any loose teeth?	Y N	13. Have you had periodontal work?	Y N
6. Do you have any sores or lumps in your mouth?	Y N	14. Have you had orthodontal work?	Y N
7. Have you had any head,neck,or jaw injuries?	Y N	15. Have you ever had prolonged bleeding?	Y N
8. Have you ever experienced any of the following problems in your jaw?		16. Have you ever had instruction on the	
A) Clicking?	Y N	- Correct method of brushing your teeth?	Y N
B) Pain (joint,ear,side of face)?	Y N	- Correct method of brushing your gums?	Y N
C) Difficulty opening or closing?	Y N	- Correct method of flossing your teeth?	Y N
D) Difficulty in chewing?	Y N	- Frequency of brushing?	Y N
		- Frequency of flossing?	Y N

WHY ARE YOU HERE TODAY? _____

DATE OF LAST DENTAL EXAM _____ PREVIOUS MAJOR DENTAL TREATMENT? Y N

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____

1. Are you under medical treatment now? _____
2 .Have you ever been hospitalized? _____
3. Do you use tobacco, alcohol, cocaine, or other drugs? _____
4. Are you wearing contact lenses? Yes _____ No _____
5. List any medications you are currently taking: _____.
6. WOMEN ONLY: Are you nursing, taking birth control pills, pregnant or think you might be pregnant? (please circle)
7. Are you allergic to or have you had any reactions to the following: (please circle)
   Local anesthetics (e.g. novocaine), penicillin/other anti-biotics, sulfa drugs, iodine, latex
8. Please list ANY allergies that you have: _____.