

Full Name: _____ Date of Birth: _____
yy/mm/dd

Home Address: _____

Postal Code: _____ Telephone: () _____

Email Address: _____

Whom may we thank for referring you to our office? _____

Medical History

If you are unsure of any of the following questions, please ask for assistance.

Name of physician: _____

Are you under the care of a specialist? Yes No

Telephone: () _____

Name of specialist: _____

Telephone: () _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| Have you had a medical examination in the last year? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a serious illness? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your doctor treating you now? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been warned not to take certain medications or food? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any allergies? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had an unusual reaction to any medication or injection? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have Diabetes? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have high blood pressure? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had Rheumatic Fever or Scarlet Fever? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have abnormal bleeding? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any previous surgery? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking any prescription or non-prescription medicines regularly? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Please list, indicating purpose and frequency of use: _____ | | |
| _____ | | |
| _____ | | |

Have you had any ill effects from any of the following? *(please circle)*

Penicillin	292	Aspirin	Codeine	Advil	Barbituates	Latex
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Others: _____

- Is your eyesight: Good Adequate Poor *(please circle)*
- Do you wear corrective lenses? _____
- Do you have hearing difficulties? _____
- Have you had any organ transplants, pacemaker or medical artificial implants? _____
- Do you have any condition that could affect your immune system (eg. AIDS, liver disease, HIV positive, Splenectomy, Leukemia, etc.)? _____
- Do you bruise or clot slowly? _____
- Do you smoke or chew tobacco? _____
- Frequency? _____

For women only:

Are you pregnant? _____

If so, what month are you in? _____

Do you take birth control pills? _____

Have you ever been treated for any of the following?

- | | | | | | |
|------------------------|--------------------------|-----------------|--------------------------|------------------|--------------------------|
| Chest Pains | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | Blood Disorders | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> |
| Bronchitis | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | Stomach Ulcers | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> |
| Drug/Alcohol Addiction | <input type="checkbox"/> | Sinusitis | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> |
| Joint Replacement | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | Herpes | <input type="checkbox"/> |
| HIV | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> |
| Kidney Disease | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | | |

Is there any other medical condition/problem the doctor should be aware of? Yes No
Please identify: _____

Personal Data:

Employed by: _____ Occupation: _____
 Business Phone: _____ Marital Status: _____
 Spouse's Name: _____ Employed by: _____
 Person responsible for this account: _____
 Address if different from above: _____
 In case of emergency please call: _____ Telephone: () _____
 Do you have dental insurance? Yes No Insurance Company Name: _____
 Policy/Group Number: _____ Certificate/ID Number: _____
 Do you have secondary insurance through your spouse? Yes No Spouse's date of birth: _____
yy/mm/dd
 Policy Group Number: _____ Certificate/ID Number: _____
 Insurance Company Name: _____

Please Note

Your appointment time is especially reserved for you. If you cannot keep the appointment, we require two business days advance notice. If we are not notified, you will be charged for that lost time. Services are to be paid at each visit as they are performed. In special circumstances, arrangement for payment can be made prior to treatment. Overdue accounts are subject to a 2% service charge (compounded monthly) and accounts beyond 120 days are forwarded to external collections, where all recovery costs to do so will be included in the account.

I, the undersigned, certify that I have provided an accurate and complete health history and have not knowingly omitted any information. I have understood all of the questions asked, and have had the opportunity to ask questions and receive explanations regarding my health history. Should there be any change in my health status in the future, I will advise this dental office. As a new patient to the office, I understand that diagnostic procedures/tests may be necessary to determine treatment, and my verbal consent to the taking of x-rays and the carrying out of other specific diagnostic tests may be required. I further understand that it may be necessary to consult with my physician or another health care professional regarding my current health status, and that my consent to contacting such persons for this purpose will be required. I also understand that responsibility for payment of the dental services for my dependents and myself is mine, and I assume responsibility for fees associated with these services.

Date: _____ Signature: _____

Full Name: _____ Date of Birth: _____
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Dental History:

When was your last dental examination? _____
 When was your last full mouth series of x-rays of jaws and teeth? _____
 Who was your last dentist? _____
 Why did you change dentists? _____
 How often do you brush your teeth? _____
 What other dental aids do you frequently use? _____ Floss? _____

	Yes	No
Do any medical problems impede your cleaning abilities? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed with flossing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you presently have any pain in chewing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any missing teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
If yes, have these teeth been replaced? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you notice any clicking or cracking of the jaws in opening? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a tooth extracted? _____	<input type="checkbox"/>	<input type="checkbox"/>
If yes, were there any complications? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of bad breath or tastes in your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has any of your previous dental work been done with a local anaesthetic? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you bite your cheeks or lips frequently? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? _____ Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars <input type="checkbox"/> Number per day: _____		
Are you tense during dental visits? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are there emotional concerns regarding your dental visit? Fear <input type="checkbox"/> Pain <input type="checkbox"/> Embarrassment <input type="checkbox"/> Other <input type="checkbox"/>		
Are you active in sports? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear recommended mouth guard protectors? _____	<input type="checkbox"/>	<input type="checkbox"/>

Check any of the following that you are interested in:

- | | |
|---|---|
| Orthodontics (Braces) <input type="checkbox"/> | Improving gum health <input type="checkbox"/> |
| Bonding (Esthetic Straightening) <input type="checkbox"/> | Improving breath <input type="checkbox"/> |
| Replacing missing teeth <input type="checkbox"/> | Crowns (Caps) <input type="checkbox"/> |
| Whitening teeth <input type="checkbox"/> | Sports Mouth Guard <input type="checkbox"/> |
| Improving bite and smile <input type="checkbox"/> | Implants <input type="checkbox"/> |

If you could change the appearance of your teeth in any way, what would you change?

Thank You!

Date: _____ Signature: _____