



We are happy to have you join our family of patients and friends. The benefits of a healthy beautiful smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible. Thank you

Today's Date \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_

Name \_\_\_\_\_ Male  Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_ Cell \_\_\_\_\_

E-mail address \_\_\_\_\_ @ \_\_\_\_\_ Birth date \_\_\_\_\_

Social Security # \_\_\_\_\_ Your Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

Ins. Co. Phone # \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Subscribers Name \_\_\_\_\_ Subscribers Social Security # \_\_\_\_\_

**Dental History**

	Yes	No	Don't Know	Notes
<i><b>Clench your teeth during the day?</b></i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i><b>Grind your teeth at night?</b></i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i><b>Sleep with your mouth open?</b></i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i><b>Chew tobacco or smoke?</b></i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Consume alcohol daily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i><b>Do you snore?</b></i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i><b>Jaw pain or Discomfort?</b></i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
How often do you brush? _____				
<i><b>Does your breath concern you?</b></i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i><b>Do you have a bad taste in your mouth?</b></i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i><b>Do your gums bleed?</b></i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you Floss? How often _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnosed with periodontal disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i><b>Do you get frequent headaches?</b></i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you bite your lips or cheeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Are you happy with the appearance of your smile? Yes No Are there any changes that you would like to make to your smile? What would that be? Whiter/straighter/spaces/etc.? Please tell us.

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## Medical History

Name of personal physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Have you had a serious health condition in the past 5 years? \_\_\_\_\_

(For women) Are you pregnant? Yes No (if yes what is your due date? \_\_\_\_\_)

Are you currently taking any prescription medications? \_\_\_\_\_ if so, please list them \_\_\_\_\_

Are you currently taking Bisphosphonates? ie, Fosamax or Boniva? Yes No Is so, how long? \_\_\_\_\_

Have you ever taken Phen Fen? Yes No If so, when \_\_\_\_\_

### Please check if you are allergic to any of the following:

- |  |  |  |                                      |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Sulfa drugs       | <input type="checkbox"/> Penicillin/ other antibiotics | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Aspirin           | <input type="checkbox"/> Shellfish, Iodine | <input type="checkbox"/> Latex                         |                                      |

### Do you have, or have you had, any of the following?

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Artificial Joints          | <input type="checkbox"/> Bruise easily       |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Blood transfusion        | <input type="checkbox"/> Breathing problems         | <input type="checkbox"/> Glaucoma            |
| <input type="checkbox"/> Artificial Heart Valve    | <input type="checkbox"/> Cancer _____             | <input type="checkbox"/> Chemotherapy               | <input type="checkbox"/> Cortisone Meds      |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Convulsions                | <input type="checkbox"/> Tumors/Growths      |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Drug Addiction           | <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Chest Pains         |
| <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Pace Maker          |
| <input type="checkbox"/> Hepatitis A               | <input type="checkbox"/> Hepatitis B or C         | <input type="checkbox"/> Herpes                     | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Kidney problems           | <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> AIDS                       | <input type="checkbox"/> Low Blood Pressure  |
| <input type="checkbox"/> Radiation Therapy         | <input type="checkbox"/> Sinus Trouble            | <input type="checkbox"/> Stomach/Intestinal Disease | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Sexual Trans Disease      | <input type="checkbox"/> Tonsillitis              | <input type="checkbox"/> Tuberculosis               | <input type="checkbox"/> MVP                 |
| <input type="checkbox"/> Ulcers                    | <input type="checkbox"/> Jaundice                 | <input type="checkbox"/> Sleep Apnea                | <input type="checkbox"/> Other _____         |

Is there any additional information you would like to provide to us to make your visit here a pleasant one?

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I agree that all of the above information is true to the best of my knowledge. I will advise of any new medical conditions as they occur.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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