TODAY'S DATE ____________

PATIENT INFORMATION AND HEALTH HISTORY

☐ MR. ☐ MS ☐ MISS NAME: ____

FIRST MIDDLE INITIAL LAST

☐ MRS. ☐ DR. BIRTH DATE: ____________

ADDRESS: ____

CITY/STATE/ZIP: ____

EMPLOYER: ____________________ OCCUPATION: ____________________

SS#: ____________ HOME PHONE: ____________ WORK PHONE: ____________

CELL PHONE: ____________ EMAIL: ____________________

FAMILY PHYSICIAN: ____________________ PHONE: ____________________

ARE YOU UNDER A PHYSICIAN'S CARE NOW? Y ☐ N ☐ IF YES, WHY? ____________________

ARE YOU TAKING ANY MEDICATIONS AT THIS TIME? Y ☐ N ☐

IF YES, WHICH ONES? ____

HAVE YOU EVER HAD AN UNUSUAL REACTION TO A MEDICATION, METAL, LATEX OR ANESTHETIC? Y ☐ N ☐

IF YES, PLEASE EXPLAIN: ____

HAS YOUR PHYSICIAN RECOMMENDED THAT YOU PREMEDICATE BEFORE DENTAL TREATMENT? Y ☐ N ☐

ARE YOU CURRENTLY BEING TREATED BY AN ORTHODONTIST OR PERIODONTIST? Y ☐ N ☐ IF YES – NAME: ____________

WHEN WAS YOUR LAST DENTAL EXAM? ____________ HAVE YOU EVER HAD A RETAINER OR BRACES? Y ☐ N ☐

DO YOU WEAR ANY DENTAL APPLIANCE NOW? Y ☐ N ☐ IF YES, PLEASE DESCRIBE: ____________________

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE OR HAVE HAD:

- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Prosthetic Implant (Re: hip, knee, etc.)
- ☐ Pacemaker
- ☐ Heart Disease
- ☐ Angina
- ☐ Infectious Hepatitis
- ☐ Liver Disease
- ☐ HIV Positive/AIDS
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Anemia
- ☐ Diabetes
- ☐ Stroke
- ☐ High or Low Blood Pressure
- ☐ Epilepsy
- ☐ Fainting/Dizziness
- ☐ Tuberculosis
- ☐ Tobacco Use
- ☐ Kidney Disease
- ☐ Asthma
- ☐ Venereal Disease
- ☐ TMJ Problems
- ☐ Stomach Disorders
- ☐ Tumors/Growth/Cancer
- ☐ Headaches
- ☐ Migraine
- ☐ Neck or Shoulder Aches
- ☐ Psychiatric Treatment
- ☐ Clenching or Grinding Teeth
- ☐ Frequent Cold Sores
- ☐ Sensitive Teeth
- ☐ Other

DO YOU HAVE DENTAL INSURANCE? Y ☐ N ☐

HOW CAN WE ASSIST YOU TODAY? ____

SIGNATURE ____________________ REFERRED BY ____________________