Date_____
Month/Day/Year

Please take a few moments to answer the following questions so that we can better assist you with your dental needs.

PATIENT REGISTRATION INFORMATION (Please Print)

Name: _____
Last Name First Name Middle Initial

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

If married, name of spouse: _____

If under 18, name of parent or guardian: _____

Name of person who is responsible for payment: _____

Mailing address: _____

Home address (street and district): _____

Phone: Home: _____

Work: _____

Cell: _____

Email: _____

Occupation: _____

Employer: _____

Dental Insurance Company: _____

Policy number: _____

NEW PATIENTS: Whom may we thank for referring you? _____

_____

PLEASE LET THE OFFICE KNOW OF ANY CHANGES OR UPDATES TO YOUR INFORMATION SO THAT WE MAY CONTINUE TO SERVE YOU BETTER

THANK YOU

MEDICAL HISTORY

Date_____
Month/Day/Year

Name:_____

Date of Birth:_____ Age:_____

Please ask about any questions which are not understood so we can serve you better.

Medical physician's name and address:_____

Approximate date of last medical exam:_____

1. Are you currently undergoing medical treatments? ..... YES NO
2. Are you currently taking any medicines? ..... YES NO

Please list medications: .....

3. Are you Pregnant? ..... YES NO

Do you have, or ever had, any of the following:

4. Sensitivity or allergy to any medicines (please list below).... ..... YES NO
5. Asthma or any other allergies (please list below) ..... YES NO
6. High blood pressure ..... YES NO
7. Low blood pressure ..... YES NO
8. Heart condition (including murmer, mitral valve prolapse, (artificial valve, pacemaker, etc.) ..... YES NO
9. Rheumatic fever ..... YES NO
10. Stomach ulcer ..... YES NO
11. Diabetes ..... YES NO
12. Tuberculosis ..... YES NO
13. Kidney problems ..... YES NO
14. Liver disorder (ex. Jaundice or Hepatitis) ..... YES NO
15. HIV (aids virus) ..... YES NO
16. Thyroid condition ..... YES NO
17. Cancer ..... YES NO
18. Artificial joint / implants (ex. hip or knee). .... YES NO
19. Epilepsy ..... YES NO
20. Please circle if you smoke: pipe, cigarettes, cigars ..... YES NO
21. Do you smoke more than one pack per day? ..... YES NO
22. Have you had any serious illnesses or operations? ..... YES NO
23. Any other disease, condition/medical problem not listed above. ..... YES NO

Notes:_____

_____

Patients signature:_____(parent if patient is under 18)

(Updates on reverse side)

Personal Dental History

Name _____ Date _____

Do you have any pain/discomfort? _____

Approximate date of last dental visit? _____

* What was done? _____ * Did you have x-rays? _____

How frequent are your teeth: Professionally examined? _____ Cleaned? _____

Do you have any missing Teeth? _____ If so, why? _____

* Missing Teeth replaced by: (circle) Fixed bridge (non-removeable) Removable denture Implant(s)

Any complications with healing after tooth removal? _____

Have you had any injuries to your teeth or mouth area? _____

Are any teeth sensitive to: (circle) Heat Cold Sweets Pressure

Have you ever had orthodontic treatment (braces)? _____ When? _____

Brand of Toothpaste: _____ Brand of Mouthwash: _____

Type of Toothbrush: _____ Texture of Brush: Soft_____ Medium_____ Hard_____ Electric_____

How do you clean between your teeth? Floss_____ Water Pik_____ Toothpick_____ Other_____

Do your gums ever bleed? _____ When? _____

Have you ever had periodontal (gum) treatment? _____ Type and date? _____

Have any of your relatives lost all of their teeth? _____

Do you eat snack foods?	Y	N	Any difficulty chewing?	Y	N
Is there much sugar in your diet?	Y	N	Any digestion problems?	Y	N
Are you prone to tooth decay?	Y	N	Does food catch between your teeth?	Y	N
Difficult breathing through nose?	Y	N	Do you experience dry mouth?	Y	N
Do you gag easily?	Y	N	Any swelling, lumps, sores in mouth?	Y	N
Are you fearful of dental treatment?	Y	N	Allergic reaction to metal jewelry?	Y	N
Specific Fears: _____			Do you clench/grind your teeth?	Y	N

Pain around ears? _____ TMJ syndrome? _____ Clicking of jaw? _____

If you could have your teeth any way that you wish, would you change anything about them? _____

_____

How do you feel about your teeth? _____

What is important to you about your teeth? (rate on a scale from 0 to 10) _____

Appearance_____ Function (bite, chew, speak)_____ Comfort (no pain)_____

Health (no infection) _____ Pleasant breath and taste _____ Avoid Future Problems_____

Notes: _____

_____

_____

_____