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Name: Mr. Mrs. Ms. Dr._____
First Middle Last
Preferred Name:_____ Date of Birth:_____
Residence Address:_____ Home Phone:_____
City:_____ State:_____ Zip:_____ Cell Phone:_____
Name & Address of Employer:_____
_____
_____

Spouse's Name:_____ Spouse's Employer:_____
Spouse's Date of Birth:_____ Your Insurance Company:_____ Insurance Co. Phone:_____
Policy Number:_____
Purpose of Visit:_____ Referred by:_____
Your Social Security Number: _____Spouse's Social Security Number:_____

Dental History
Date of last dental visit:_____ Date of latest complete set of x-rays (14+ films)_____
How often do you have your teeth cleaned?_____ Do your gums bleed when you brush?_____
How often do you floss? _____ Have you ever been shown how to floss?____
Do you clench or grind your teeth?_____ Does your jaw ever pop or click?_____
Have you ever had braces?_____ Have you ever had wisdom teeth removed?__
Are you missing any other teeth?_____ If so, has anyone ever mentioned bridgework?_____
Are you happy with the appearance of your teeth?_____ If not, what would you change?_____
Have you had any unpleasant dental experiences in the past? _____

Medical History
Name of physician:_____ Date of last physical:_____
Please circle any of the following that have ever applied to you:

Heart trouble or attack	High or low blood pressure	Rheumatic or scarlet fever
Dizziness or fainting	Frequent or severe headaches	Diabetes
Thyroid problems	Sinusitis, hay fever, asthma	Ear trouble
Alcoholism	Kidney of bladder trouble	Anemia
Tuberculosis	Heart murmur or defects	Heart Surgery
Prostate problems	Glaucoma	AIDS / ARC / HIV
Artificial joints	Epilepsy or other seizures	Lupus
Hepatitis or jaundice	Stomach ulcers or other problems	Liver disease
Mitral valve prolapse	Blood transfusion	Stroke
Heart pacemaker	Artificial heart valve	Abnormal bleeding
Cancer	Tumors	Drug use or abuse
Fever blisters	Tobacco use (cigar, cigarette, snuff)	Organ transplants

Are there any medications that you have a known allergy or reaction to? _____

Have you ever been told not to take Novacaine or local anesthetics?_____

Are you taking any medications regularly?_____

Are there any other conditions we should know about?_____

Women: Is there any possibility you could be pregnant?_____ Are you taking birth control pills?_____

Signature:_____Date:_____