Patient Information

Name_____Date_____

Street_____City_____State_____Zip_____

Home Phone _____Alternate Phone_____

Date of Birth_____ SSN _____ Male _____Female_____

Marital Status_____ Spouse's Name_____

E-Mail address_____

Employer_____ Occupation_____

Address_____ Work Number _____EXT_____

City_____State_____Zip_____

Insurance Information

Will you be using dental insurance for your treatment? _____Yes _____No

Referral Information

Referred By_____

Family Dentist_____ How Long_____

Physician_____ Phone Number_____

Dental History

What is your biggest concern about your gums, mouth, or teeth?

Have you had periodontal treatment before? If yes, when and where?

How often and when was your last cleaning?

How would you feel if you had to lose teeth?

What are you currently doing for your oral health care? Check all that apply.
Flossing/how often_____ Brushing/how often (Manual**)** _____ (Electric**)**_____
Water pick_____ Proxabrush_____ Mouthrinse_____ Other_____

Check all that apply to you

( ) Swollen or bleeding gums	( ) Bad breath or mouth odor	( ) Bad tastes
( ) Painful gums or teeth	( ) Sensitivity to hot or cold	( ) Clenching or grinding
( ) Loose teeth	( ) Increasing space between teeth	( ) Unhappy with smile
( ) Snoring/Sleep Apnea	( ) Jaw/Joint pain	( ) Other

Medical History

	Yes	No
1. **Do you have any known allergies? If yes, list**_____	____	____
2. Have you had any serious illness, operation, or hospitalization in the past?.....	____	____
3. Are you presently under the care of a physician?.....	____	____
4. Do you smoke or use tobacco products? How much?_____ How long?_____.....	____	____
5. Do you drink alcoholic beverages more than 3-4 times a week?	____	____

HAVE YOU HAD ANY OF THE FOLLOWING?

	Y	N		Y	N
HIGH BLOOD PRESSURE			DIABETES		
HEART MURMURS			THYROID DISORDERS		
PROLAPSED MITRAL VALVE			BLEEDING PROBLEMS		
RHEUMATIC FEVER			BLOOD DISORDERS		
HEART PROBLEMS			ARTHRITIS		
ANGINA			JOINT IMPLANTS		
HEART ATTACK			NERVOUS DISORDERS		
PACEMAKER			EPILEPSY/SEIZURES		
STROKE			HEADACHES		
TUBERCULOSIS			STEROIDS IN LAST 2 YEARS		
EMPHYSEMA			CANCER		
ASTHMA			RADIATION/CHEMOTHERAPY		
DIALYSIS			COMPLICATION WITH ORAL SURGERY		
KIDNEY DISEASE			OSTEOPOROSIS		
ALCOHOL/CHEMICAL DEPENDENCY			**WOMEN ONLY ARE YOU CURRENTLY:**		
HEPATITIS/LIVER DISEASE			PREGNANT		
HIV+/AIDS			BREAST FEEDING		
			MENSTRUAL PROBLEMS		

9.List **any** drugs or medicines that you are currently taking to include prescription/non-prescription drugs, aspirin, birth control, vitamins, and herbs.

DRUG	DOSAGE/HOW OFTEN?	HOW LONG

PATIENT SIGNATURE_____DATE_____

OFFICE USE ONLY----------

Blood pressure_____/pulse_____

Medical history reviewed\updated on:_____Date_____Doctor