WELCOME TO OUR OFFICE

Date_____ /_____ /_____

Patient_____
Last Name First Name MI SS# Date of Birth Marital Status

Spouse/Parent_____
Last Name First Name MI SS# Date of Birth

Other household members:

_____
Last Name First Name MI Age Regular Dentist Regular Checkups (Y/N)

_____
Last Name First Name MI Age Regular Dentist Regular Checkups (Y/N)

_____
Last Name First Name MI Age Regular Dentist Regular Checkups (Y/N)

Residence_____
Address Apartment # City State ZIP Code

How long at this residence?_____ Home Phone_____ Work Phone_____

Cell #_____ E-mail Address_____

Previous Address *(If Less Than 3 Years)* _____
Address City State ZIP Code

Patient's Employer_____Occupation_____Years Employed_____

Spouse's/Parent's Employer_____Occupation_____Years Employed_____

Dental Insurance Co._____ Other Dental Ins. Co._____

Name Of Responsible Party_____
Last Name First Name MI Relationship

In case of emergency, who should we contact?_____ Telephone_____

Whom may we thank for referring you to our care?_____

MEDICAL HISTORY

Personal Physician_____ Date of Last Physical Exam_____

Pharmacy_____Telephone_____

Have you been under your physician's care or hospitalized in the last several years? Please describe: _____

_____

_____

Please check any of the following which you have had or presently have:

❑ Bypass Surgery	❑ Emphysema	❑ Injury to Head/Neck	❑ Heart Attack	❑ Ulcers
❑ Stroke	❑ Liver Disease	❑ Hepatitis B or C	❑ Ear/Head Aches	❑ Facial/Neck Pain
❑ Angina	❑ Asthma	❑ High Blood Pressure	❑ A.I.D.S./HIV Positive	❑ Tuberculosis (TB)
❑ Low Blood Pressure	❑ Diabetes	❑ Blood Transfusion	❑ Heart Murmur	❑ Drug Addiction
❑ Sinus Problems	❑ Nervousness	❑ Hemophilia	❑ Rheumatic Fever	❑ Allergies or Hives
❑ Fever Blisters	❑ Arthritis	(Bleeding Problems)	❑ Scarlet Fever	❑ Mitral Valve Prolapse
❑ Epilepsy or Seizures	❑ Alcoholism	❑ Anemia	❑ Thyroid Disease	❑ Heart Pacemaker
❑ Psychiatric Treatment	❑ High Cholesterol	❑ Artificial Joint	❑ Glaucoma	❑ Artificial Heart Valve
❑ Chemotherapy	❑ Osteopenia	(Hip, Knee, Jaw)	❑ Venereal Disease	❑ Kidney Problems
(Cancer, Leukemia)	❑ Osteoporosis	❑ Bruise Easily	❑ Dry Mouth	❑ Nicotine Usage
❑ Radiation Treatment				

What medications are you presently taking?_____

_____

Do you take Tagamet or Inderal? ❑ Yes ❑ No Fosamax, Actonel ❑ Yes ❑ No If yes, how often?_____

Are you allergic to: ❑ Penicillin ❑ Local Anesthetics ❑ Codeine ❑ Aspirin ❑ Nitrous Oxide (Laughing Gas) ❑ Latex ❑ Colored Dyes

List other allergies:_____

_____

Women – Are you: Pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

OVER PLEASE

DENTAL HISTORY

What is the reason for your visit today?_____

_____

What concerns you most about your present health? (Inability to chew, Discomfort, Appearance, Previous dental care, etc.)

_____

_____

Do you understand what kind of dentistry a Prosthodontist performs?

❑ Yes ❑ No ❑ Not Sure

When was your last dental exam and/or cleaning?_____

May we include you in our regular preventive care program? This includes cleaning, clinical exam and x-rays, when indicated.

❑ Yes ❑ No

Is there anything about having dental treatment that you would like us to know? ❑ Yes ❑ No

If yes, please describe_____

_____

Do you feel nervous about dental treatment? ❑ Yes ❑ No

If yes, what is your biggest concern?_____

_____

Previous Dentist's Name_____Telephone_____

Other Dental Specialists currently seeing (Oral Surgeon, Periodontist, Endodontist, Pediatric Dentist, Orthodontist):_____

_____

Do you have or have you had any of the following dental conditions or procedures:

- ❑ Periodontal Disease
- ❑ Food packing between teeth
- ❑ Orthodontics
  - If yes, when?_____
- ❑ Orthognathic (jaw) Surgery
- ❑ Endodontics (Root Canals)
- Sensitivity to:
  - ❑ Hot
  - ❑ Cold
  - ❑ Sweet
- ❑ Crowns (caps)
- ❑ Loss of permanent teeth
- Permanent teeth replacement:
  - ❑ Fixed
  - ❑ Removable
  - ❑ Implants
- ❑ TMJ Therapy
- ❑ Occlusal Equilibration (bite adjustment)
- ❑ Occlusal Splints
- ❑ Traumatic blow to teeth or jaws

Additional dental information_____

_____

This information is correct and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance benefits for which I am entitled. I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health care practitioners. I authorize the release of any medical information by my physician as it pertains to my dental care and the use of photographs of my dental treatment (teeth only) for publication and/or teaching purposes. I understand that where appropriate, credit bureau reports may be obtained.

_____

Signature of patient or parent of minor

We thank you very much for this information.