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? _____________________________________ Phone Number_________________

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

MEDICAL HISTORY

Personal Physician____ Phone Number __________________
Pharmacy____ Phone Number __________________

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:

❑ Alcoholism	❑ Bypass Surgery	❑ Fever Blisters	❑ Kidney Problems	❑ Rheumatic Fever
❑ Allergies or Hives	❑ Chemotherapy	❑ Glaucoma	❑ Liver Disease	❑ Scarlet Fever
❑ Anemia	❑ Cognitive Problems	❑ Heart Attack	❑ Low Blood Pressure	❑ Sinus Problems
❑ Angina	❑ Diabetes	❑ Heart Murmur	❑ Mitral Valve Prolapse	❑ Stroke
❑ Arthritis	❑ Drug Abuse	❑ Hemophilia	❑ Nervousness	❑ Thyroid Problems
❑ Artificial Heart Valve	❑ Dry Mouth	❑ Hepatitis B or C	❑ Osteopenia	❑ Tobacco Use
❑ Artificial Joint	❑ Ear/Head Aches	❑ High Blood Pressure	❑ Osteoporosis	❑ Tuberculosis (TB)
❑ Asthma	❑ Emphysema	❑ High Cholesterol	❑ Pacemaker	❑ Ulcers
❑ Blood Transfusion	❑ Epilepsy or Seizures	❑ HIV Positive/AIDS	❑ Psychiatric Treatment	❑ Venereal Disease
❑ Bruise Easily	❑ Facial/Neck Pain	❑ Injury to the Head/Neck	❑ 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 Name______________________________ Phone Number ____________________

Other Dental Specialist 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 (Night Guard)
❑ 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.

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Signature of patient or parent of minor

We thank you very much for this information.