About You

Today's Date: _____

Patient's Name (Mr. Mrs. Ms. Dr.) _____ Nickname: _____

SS#: _____ Birthday: _____ Gender: ○Male ○Female Marital Status: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

Whom may we thank for referring you? _____ Other family members seen by us: _____

Whom may we notify in case of an emergency? _____ Phone: _____ Relation: _____

Dental History

Referring Dentist (if applicable): _____ Date of last dental visit: _____

Your Previous Dentist: _____ City: _____ How long?: _____

My current dental health is: ○Good ○Fair ○Poor

Date of last professional dental cleaning?: _____ # cleanings per year: _____ Date of last full set of x-rays?: _____

What brings you here today? _____

PREVIOUS DENTAL HISTORY:

Do you or have you had any of the following?

a. Head or neck injuries..... ○Yes ○No
b. Sore or sensitive teeth..... ○Yes ○No
c. Bleeding gums..... ○Yes ○No
d. Clenching or tooth grinding habit..... ○Yes ○No
e. Difficulty Chewing..... ○Yes ○No
f. Anxiety towards dental treatment..... ○Yes ○No
g. Orthodontic treatment..... ○Yes ○No
h. Periodontal treatment (deep cleanings)..... ○Yes ○No
i. Trouble opening/closing your jaw..... ○Yes ○No
j. Bleeding/slow healing after an extraction.. ○Yes ○No
k. Dissatisfaction with your smile..... ○Yes ○No

Medical History

Are you currently under the care of a physician? ○Yes ○No Date of last medical visit: _____

Physician's Name: _____ Address: _____ Phone: _____

My current health is: ○Good ○Fair ○Poor

Pharmacy name: _____ City: _____ Phone: _____

Current Height: _____ Weight: _____ Blood Pressure: _____

Do/Did you smoke? ○Yes ○No How many packs/day? _____ For how many years? _____ Quit? When: _____

WOMEN:

Are you taking Birth Control?..... ○Yes ○No

Are you Pregnant? ..... ○Yes ○No

a. If yes, How many weeks? _____

If you're postpardum, are you nursing?..... ○Yes ○No

Signature: _____ **Date:** _____ **Reviewed By:** _____