
230 Columbia Blvd., St. Helens, OR 97051
(503)397-0080

**General Information**

Name:_____ _____
Last First MI Date of Birth

Residence
Address _____
Number Street City State Zip Code

Telephone _____
Home Business Cell

Business _____ _____
Employer Occupation Social Security Number

**Referral Source: [ ] Friend/Family(name)_____ [ ] Internet [ ] Phone book [ ] Drive By [ ] Other _____**

**Dental Insurance Information**

_____ _____ _____
Subscriber's Name Social Security Number Subscriber's DOB

_____ _____
Employer Policy/ID Number

_____ _____
Group Number Telephone Number

_____
Insurance Address Street City State Zip Code

**Secondary Dental Insurance**

_____ _____ _____
Subscriber's Name Social Security Number Subscriber's DOB

_____ _____
Employer Policy/ID Number

_____ _____
Group Number Telephone Number

_____
Insurance Address Street City State Zip Code

Patient's Name: _____ Date of Birth: _____

Physician's Name: _____ Phone: _____

Date of last visit: _____

**Do you have or have you ever had any of the following?**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| ADHD: | ____ | ____ | Heart Disease: | ____ | ____ |
| AIDS/HIV: | ____ | ____ | Heart Murmer: | ____ | ____ |
| Alzheimer's Disease: | ____ | ____ | Heart Problems: | ____ | ____ |
| Anemia: | ____ | ____ | Hemophilia: | ____ | ____ |
| Angina: | ____ | ____ | Hepatitis A: | ____ | ____ |
| Anaphylaxis: | ____ | ____ | Hepatitis B/C: | ____ | ____ |
| Arthritis/Rheumatism: | ____ | ____ | Hyperglycemia: | ____ | ____ |
| Artificial Heart Valves: | ____ | ____ | High Blood Pressure: | ____ | ____ |
| Artificial Joints: | ____ | ____ | Kidney Disease: | ____ | ____ |
| Asthma: | ____ | ____ | Leukemia: | ____ | ____ |
| Back Problems: | ____ | ____ | Low Blood Pressure: | ____ | ____ |
| Blood Disease: | ____ | ____ | Liver Disease: | ____ | ____ |
| Bruise Easily: | ____ | ____ | Lung Disease: | ____ | ____ |
| Herpes: | ____ | ____ | Mental Disorders: | ____ | ____ |
| Cancer: | ____ | ____ | Mitral Valve Prolapse: | ____ | ____ |
| Chemotherapy or Radiation: | ____ | ____ | Pain in Jaw Joints: | ____ | ____ |
| Chest Pain: | ____ | ____ | Psychiatric Care: | ____ | ____ |
| Cold Sores: | ____ | ____ | Renal Dialysis: | ____ | ____ |
| Congenital Heart Disorders: | ____ | ____ | Rheumatic Fever: | ____ | ____ |
| Convulsions: | ____ | ____ | Scarlet Fever: | ____ | ____ |
| Cortisone Treatments: | ____ | ____ | Shingles: | ____ | ____ |
| Diabetes: | ____ | ____ | Sickle Cell Disease: | ____ | ____ |
| Drug Addiction: | ____ | ____ | Sinus Trouble: | ____ | ____ |
| Emphysema: | ____ | ____ | Spina Bifida: | ____ | ____ |
| Epilepsy or Seizures: | ____ | ____ | Stomach Intestinal Disease: | ____ | ____ |
| Fainting/Dizzy Spells: | ____ | ____ | Stroke: | ____ | ____ |
| Frequent Cough: | ____ | ____ | Swelling of Limbs: | ____ | ____ |
| Frequent Headaches: | ____ | ____ | Thyroid Disease/Problems: | ____ | ____ |
| Glaucoma: | ____ | ____ | Tuberculosis: | ____ | ____ |
| Hay Fever: | ____ | ____ | Tumors or Growths: | ____ | ____ |
| Heart Attack: | ____ | ____ | | | |

**Allergies:**

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Aspirin: | ____ | ____ | Acrylic: | ____ | ____ | Anesthetics: | ____ | ____ |
| Codeine: | ____ | ____ | Latex: | ____ | ____ | Penicillin: | ____ | ____ |
| Metal: | ____ | ____ | | | | | | |

Other Medications: _____

1. Are you pregnant? _____ 2. Are you nursing? _____
3. Do you take any oral contraceptives? _____
4. Do you smoke? _____ 5. Do you chew tobacco? _____
6. Have you ever had a problem with bleeding after any type of surgery (medical or dental)? _____
7. Do you have excessive thirst? _____
8. Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, and Boniva. _____
9. Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Tlonimin, Adipex, Fastin, Pondimin and Redux. _____
10. Have you ever been hospitalized or had a major operation? If so, for what? _____
11. Have you ever had a serious head or neck injury? If so, when? _____
12. Do you use controlled substances? _____
13. Have you had a recent weight loss? _____ 14. Are you on a special diet? _____

**Medications you are taking and why:**

_____
_____

**DENTAL HISTORY**

Reason for today's visit: _____ Former Dentist: _____
Date of last dental visit: _____ Date of last dental x-rays: _____
Have you ever had braces? _____ Date: _____
How often do you floss? _____ How often do you brush your teeth? _____
Have you ever had periodontal (gum) treatment? _____ When? _____
Are any of your teeth sensitive to cold, hot, sweets, or pressure? _____ What area? _____

Do you have any of the following:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Bad Breath: | ____ | ____ | Grinding Teeth: | ____ | ____ |
| Bleeding Gums: | ____ | ____ | Gums swollen or tender: | ____ | ____ |
| Blisters on lips or mouth: | ____ | ____ | Loose or broken teeth: | ____ | ____ |
| Chew on one side: | ____ | ____ | Mouth breathing: | ____ | ____ |
| Clicking, popping or pain with your jaw: | ____ | ____ | Fingernail biting: | ____ | ____ |
| Food collects between teeth: | ____ | ____ | Growths in your mouth: | ____ | ____ |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature: _____ Date: _____
Reviewer's Signature: _____ Date: _____