Today's date _____

Family, Cosmetic & Implant Dentistry

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Patient Name _____Home Telephone _____Cell_____
Address_____Town_____State_____Zip Code_____
email_____Age___Date of Birth_____Height_____Weight_____Marital Status __
Occupation _____Work Telephone _____Employer _____
Person responsible for payment _____ Relationship _____
Dental Insurance Y/N _____Provider Name _____Address for claims_____
_____
Subscriber _____ Subscriber's D.O.B._____ Group #_____
Referred by _____

Circle Appropriate Answer (leave blank if you do not understand the question or answer D/K for Don't Know)

1. Yes No Is your general Health Good?
2. Yes No Has there been any change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   Why? _____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last Medical Exam? _____
   Physician's Name _____ Address _____
   Telephone # _____
5. Yes No Have you had problems with prior dental treatment? _____
6. Yes No Are you in pain now? _____

Have you experienced? _____

7. Yes No Chest pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness?

Do you have or have you had? _____

29. Yes No Epilepsy?
30. Yes No Heart Attack, heart defects, heart disease?
31. Yes No Heart murmurs, mitral valve prolapse, valve replacement?
32. Yes No Rheumatic fever?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No TB, emphysema, asthma, other lung disease?
36. Yes No Hepatitis, other liver disease, jaundice?
37. Yes No Stomach problems, ulcers?
38. Yes No ALLERGIES: drugs, foods, medications, latex?
39. Yes No Family history of diabetes, heart problems, tumors?
40. Yes No AIDS, ARC, or HIV?
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye disease?
44. Yes No Skin disease?
45. Yes No Anemia, blood disease?
46. Yes No VD (syphilis, gonorrhea, Chlamydia)?
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Diabetes?

PLEASE COMPLETE REVERSE SIDE

Do you have or have you had? _____

51. Yes No Psychiatric care?
56. Yes No Hospitalization?

52. Yes No Radiation treatments?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint?
57. Yes No Blood transfusion?
58. Yes No Surgeries?
59. Yes No Pacemaker?
60. Yes No Contact Lenses?

Are you taking? _____

61. Yes No Recreational drugs?
62. Yes No Drugs, medicines, (including aspirin?)
Please list:_____
63. Yes No Tobacco in any form?
64. Yes No Alcohol?
65. Yes No Do you have (or ever had) any other diseases or medical problems NOT listed on this form?
If so, please explain: _____
66. Yes No Are you happy with your smile?
If not, why not? _____

Women only: _____

67. Yes No Are you or could you be pregnant or nursing?
68. Yes No Are you taking birth control pills?

DENTAL HISTORY

Date of last dental visit _____ Reason for that visit _____
Previous Dentist – Name _____ Address _____

Have you ever received any of the following dental treatments?

Yes No Orthodontic (Braces)
Yes No Oral Surgery (Extractions, other)
Yes No Periodontic (Gum Treatment)
Yes No Endodontic (Root Canal)
Yes No Dentures (Partial or Full)
Yes No Prosthodontic (Crowns or Bridges)
Yes No TMJ (Joint Pain Dysfunction)
Yes No Cosmetic Treatment Tooth shade at initial exam _____
Yes No Implants

Today's Blood Pressure _____

Have you ever had local anesthetic? Yes No If yes, any bad reactions? Yes No

If patient is a minor:

Do you consent to necessary diagnostic X-rays? Yes No
Do you wish your child to receive a topical fluoride treatment Yes No

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication.

Patient's Signature (Parent or guardian if patient is a minor) _____

Reviewed by _____ Date completed _____