PLEASE PRINT THE FOLLOWING INFORMATION (THIS INFORMATION IS IMPORTANT!)

1. Dr., Mrs., Ms.____ Preferred Name_______________________

2. ____
Residence Address City State Zip

3. (____)_________________(_____)____
Residence Telephone Cell E-mail

4. Date of Birth_______________________ Social Security Number____

5. Single___ Married___ Divorced___ Widowed / Widower___ Other___

6. Are you a full time student? Yes____ No____ Name of School____

7. Do you have dental insurance? ___________ Insurance Company Name__________________________________

Company phone number (_____)______________ Company Group Number________________________________

8. ____
Name of Insured/Cardholder Relationship to Patient

____
Insured Employer Insured Social Security # Insured Date of Birth

9. ____
Name of husband, wife, guardian, significant other Person responsible for account

10. ____(_____)__________________________
Your Employer Occupation Work Telephone

11. ____(_____)__________________________
Spouse's Employer Occupation Work Telephone

12. ____
Name of your physician Phone # City State

13. ____
Name of your dentist City State

14. ____
Whom are we to thank for referring you to this office?

15. Emergency Contact: _________________________________ Phone (____)_____________________

PLEASE ANSWER QUESTIONS 1 THROUGH 35

1. What is your present dental problem? ____
2. Are you in any dental pain now? Yes____ No____
3. Are you in good health? Yes____ No____
4. Are you being treated by a physician for any condition? Yes____ No____
If yes, for what?____
5. Are you currently taking any medication, drugs, or pills? Yes____ No____
If yes, for what reason? ____
Please list the name(s) of the medication(s) ____
____

6. Have you ever had any of the following: Please circle all that apply

Anemia (thin blood)	Diabetes
Blood Disease	Kidney Disease
Asthma	Stomach ulcer
Lung Disease	Rheumatic Fever
Heart Disease	Liver Disease
Heart Attack	Yellow Jaundice
Heart Murmur	Hepatitis
Stroke	Other (Please specify)

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7. Blood Pressure: High_______ Normal________ Low_________
8. Are you allergic to any food or drugs? Yes_____ No_____
   If so, what?____
9. Have you ever had an unusual reaction to a local anesthetic (such as Novocaine)? Yes______ No_____
10. Do your jaw joints ever ache or pop? Yes____ No_____
11. Do you ever grind your teeth at night? Yes____ No_____
12. Do you ever clinch your teeth together during the day? Yes____ No_____
13. Are you under abnormal stress? Yes____ No_____
14. Do you bruise easily or bleed for a long time when you cut yourself? Yes____ No_____
15. Do you sleep with more than one pillow at night? Yes____ No_____
16. Are you taking hormones? Yes____ No_____
17. Have you had any surgery within the past five (5) years? Yes____ No_____
   If so, for what? ____
18. Do you use tobacco products? Yes____ No_____
19. Have you ever had surgery or radiation treatment for a tumor, growth, or other condition of your head or neck? Yes____ No_____
20. Is any part of your body numb or paralyzed? Yes____ No_____
21. Are you pregnant at this time? Yes____ No_____
22. When did you have your last physical examination? ____
   By Whom?____
23. When was your last visit to the dentist? ____
   What was done then? ____
24. When did you last have your teeth cleaned by your dentist?____
25. How often do you have your teeth cleaned? ____
26. Do you have a fixed bridge? Yes/No
   Upper?____ How long?_____ Lower?____ How long?_____
   Partial Denture? Yes/No
   Upper? _____ How long?_____ Lower?_____ How long?_____
   Complete Denture? Yes/No
   Upper?______ How long?_____ Lower?_____ How long?_____
27. Tooth brush frequency? ____times per day
28. Toothbrush type? Manual_____ electric______ soft___ medium____ hard____
29. Do your gums bleed after brushing? Yes____ No____
30. Are your teeth sensitive to heat? ____ cold?_____ sweets?____
31. Do you take vitamins? Yes____ No____
   Please list them ____
32. Are you taking aspirin daily? Yes____ No_____
33. Have you ever been exposed to the HIV virus? Yes____ No_____
34. Do you have any artificial devices, such as hip or knee replacement? Yes____ No_____
35. Do you have to take antibiotics prior to dental treatment? Yes_____ No_____

WARNING TO ALL FEMALES OF CHILDBEARING AGE

Antibiotics may be prescribed during dental treatment. These antibiotics may diminish the effectiveness of birth control pills. Additional birth control precautions should be used while on antibiotics.

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SIGNATURE OF PERSON FILLING OUT THIS FORM DATE

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