## PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

in your hearth, prease ten as: in you have any quese					
Patient name:			Date of birth: Sex:	Age: _	_
Home address:			City: State: Zip:		
	City: State: Zip:				
			Driver's license #:		
SS #: Employe	er/Occ	upation	Bus. Phone:		_
Spouse's name & phone #:			Emergency phone # (other than spouse):		
Primary dental insurance:			Group #:		
Secondary dental insurance:			Group #:		
Subscriber's name:			Date of birth: SS #:		
Name of your medical doctor:					
Name of previous dentist:			Date of last visit to dentist:		
	DEN 1 Yes	AL HE	ALTH HISTORY	Yes	N
Are you apprehensive about dental treatment?		(CONT.ENG.)	How often do you brush?		
Have you had problems with previous dental treatment?			How often do you floss?		
Do you gag easily?			Does your jaw make noise so that it bothers you	П	
Do you wear dentures?			or others?  Do you clench or grind your laws frequently?		1
Does food catch between your teeth?			3 / / / /		
Do you have difficulty in chewing your food?			Do your jaws ever feel tired?		
Do you chew on only one side of your mouth?			Does your jaw get stuck so that you can't open freely?		L
Do you avoid brushing any part of your mouth			Does it hurt when you chew or open wide to take a bite?		L
because of pain?			Do you have earaches or pain in front of the ears?		
Do your gums bleed easily?			Do you have any jaw symptoms or headaches	_	
Do your gums bleed when you floss?			upon awaking in the morning?	_[_]	L
Do your gums feel swollen or tender?	П		Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	П	
Have you ever noticed slow-healing sores in or					
about your mouth?			Do you find jaw pain or discomfort extremely		
Are your teeth sensitive?			frustrating or depressing?	_ 🖵	
Do you feel twinges of pain when your teeth come in			Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	17	I
contact with:			Do you have a temporomandibular (jaw) disorder		_
Hot foods or liquids?		Ш	(TMD)?	1 1	1
Cold loods of fiquios:	Щ		Do you have pain in the face, cheeks, jaws, joints,		_
30ui3:	Ц		throat, or temples?	П	Г
Sweets.		Ц	Are you unable to open your mouth as far as you want?		
Do you take ndonde supplements.		Ш	Are you aware of an uncomfortable bite?		
Are you dissatisfied with the appearance of your teeth?					
Do you prefer to save your teeth?			Have you had a blow to the jaw (trauma)?		_

Do you want complete dental care?

Are you a habitual gum chewer or pipe smoker? \_\_\_\_\_

## Do you have, or have you had, any of the following?

	Yes N	0		Yes	No	
Heart Problems			Diabetes			
Chest pain			Urinate more than 6 times a day			
Shortness of breath			Thirsty or mouth is dry much of the time			
Blood pressure problem			Family history of diabetes			
Heart murmur			Tuberculosis or other respiratory disease	-1		
Heart valve problem		1				
Taking heart medication	-	ļ	Do you drink alcohol?	1	.1.	
Rheumatic fever Pacemaker		l I	If so, how much?			
Artificial heart valve	_	j I	Do you smoke?			
		1	If so, how much?			
Blood Problems			Hepatitis, jaundice, or liver trouble			
Easy bruising						
Frequent nosebleeds Abnormal bleeding		l I	Herpes or other STD	,		
Blood disease (anemia)		I	HIV-positive/AIDS		i	
Ever require a blood transfusion?	1	1	Glaucoma			
			Do you wear contact lenses?			
Allergy Problems						
Flay fever			History of head injury?		_1	
Sinus problems Skin rashes			Epilepsy or other neurological disease?	_1		
Taking allergy medication			History of alcohol or drug abuse?			
Asthma						
1 1 1			Do you have any disease, condition, or prob		listed	
Intestinal Problems Ulcers			previously that you feel we should know			
Weight gain or loss			If so, please describe:			
Special diet						
Constipation/Diarrhea			During the past 12 months, have you taken			
Kidney or bladder problems	í		any of the following?	Ye	e	No
			Constituting and section in the section of the sect	10.	1	140
Bone or Joint Problems	-	ļ	Antibiotics or sulfa drugs	_	]	
Arthritis Back or neck pain			Anticoagulants (e.g., Coumadin)		1	
Joint replacement	7 -		High blood pressure medicine	_	]	
(e.g., total hip, pins, or implants)			Tranquilizers		j I	
			Insulin, Orinase, or similar drug		]	
Fainting Spells, Seizures, or Epilepsy		l	Aspirin		1	
Stroke(s)	7		Digitalis or drugs for heart trouble Nitroglycerin		1	
r Laboratoria	E-		Cortisone (steroids)		1	
Frequent or severe headaches			Natural remedies		1	H
Thyroid problems			Nonprescription drug/supplements		ĺ	П
Persistent cough or swollen glands			Other		,	
	1		50 50 50 50 50 50 50 50 50 50 50 50 50 5			
Premedications required by physician	-1	i.				
Cancer/Tumor						
			Women	Ye	.S	No
$\epsilon$ you allergic, or have you reacted adversely,			Are you taking contraceptives or			
to any of the following?	Yes	No	other hormones?		]	
Local anesthetics ("Novocaine")			Are you pregnant?		]	
Penicillin or other antibiotics			If so, expected delivery date:			
Sulfa drugs			Are you nursing?			
Barbiturates, sedatives, or sleeping pills			Have you reached menopause?			
Aspirin, Acetaminophen, or Ibuprofen			If so, do you have any symptoms?			-
Codeine, Demerol, or other narcotics			so, as journate any symptoms:	TIPE		
Reaction to metals						
Latex or rubber dam						
Other			Notes:			
otes:			-			
			Patient/Parent Signature:			
Da	te:		Dentist Initial:			