Name_____ Single ☐ M ☐ D ☐ W ☐ Date_____
LAST FIRST MIDDLE INITIAL

Social Security Number _____ Birthdate _____ Home Phone _____ Business Phone _____

Address_____ City_____ State _____ Zip_____

Employed By_____ City_____ State _____ Zip_____

Spouse Name _____

Social Security Number _____ Birthdate _____ Business Phone _____

Employed By_____ City_____ State _____ Zip_____

Person Responsible for Account_____

Name of Dental Insurance Company _____

Union Local _____ Group # _____ Policy # _____

Spouse's Insurance Co. _____

Union Local _____ Group # _____ Policy # _____

Physician_____ Whom may we thank for referring you to our office?_____

In case of emergency, contact _____ Phone _____

## MEDICAL HISTORY

Do you have or have you had any of the following? Please indicate with check mark (✓).

Women only:
____ Are you pregnant?
____ Are you nursing?
____ Are you taking birth control pills

____ Any heart problems
____ High blood pressure
____ Low blood pressure
____ Circulatory problems
____ Nervous problems
____ Radiation treatments
____ Excessive bleeding
____ Is there any reason to believe or are you HIV positive?
____ AIDS
____ Use tobacco products?
____ Allergies to anesthetics
____ Allergies to medicines/drugs
____ Allergies to _____
____ Anemia
____ Arthritis
____ Asthma
____ Diabetes
____ Drugs
____ Hepatitis
____ Herpes
____ Malignancies
____ Measles
____ Mumps
____ Psychiatric care
____ Rheumatic Fever
____ Scarlet Fever
____ Sinus problems
____ Stroke
____ Typhoid Fever
____ Tonsillitis
____ Tuberculosis
____ Ulcer
____ Venereal Disease
____ Other

**Are you now taking pills, drugs or medication?** _____ (please list) _____

## DENTAL HISTORY

| | | Yes | No |
|---|---|---|---|
| 1. | Are you having any discomfort or pain? | ❑ | ❑ |
| 2. | Are you aware of any particular dental problems? | ❑ | ❑ |
| 3. | Have you ever had abnormal bleeding following extraction of a tooth? | ❑ | ❑ |
| 4. | Have you experienced bleeding gums? | ❑ | ❑ |
| 5. | Do you use dental floss? | ❑ | ❑ |
| 6. | How often do you use dental floss? _____ | | |
| 7. | Have you ever experienced any illness or complications following dental treatment of any kind? | ❑ | ❑ |
| 8. | Do you have sinus problems? | ❑ | ❑ |
| 9. | Do you experience an unpleasant taste in your mouth? | ❑ | ❑ |
| 10. | Do you have any sores inside your mouth? | ❑ | ❑ |
| 11. | Have you visited a dentist during the past year? | ❑ | ❑ |
| 12. | Do you have any fear of having dentistry done? | ❑ | ❑ |
| 13. | Do you grind or clench your teeth? | ❑ | ❑ |
| 14. | Have you ever had pains in the face or head other than toothaches? | ❑ | ❑ |
| 15. | Have you ever had a jaw or mouth injury? | ❑ | ❑ |
| **16.** | **If you could, what would you change about your smile?** _____ | | |

Comments:_____

_____

_____

_____

_____

I understand that the information I provide on this form is essential to determine my dental needs and the provision of dental treatment; I understand that if any change occurs in my health I am to report it to the dental office as soon as possible; I have read, and understand each question, and have answered all of them truthfully and to the best of my ability; I have discussed my health history with the doctor.

Signature _____