PLEASE PRINT CONFIDENTIAL PATIENT RECORD	DATE:
*Your cooperation in filling the data on this confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain with this office.	ACCT #

PATIENT NAME		DATE OF BIRTH / /	
HOME ADDRESS	CITY	STATE	ZIP
HOME PHONE		BUSINESS PHONE	
EMERGENCY NO:		EMPLOYER	
SOC. SEC. NO: / /		MARITAL STATUS	SINGLE MARRIED
PARENT OR GUARDIAN		SOC. SEC. NO: / /	

DENTAL INSURANCE: YES / NO

DRIVERS LICENSE # STATE:

Referred by: ☐ TV ☐ TV-Guide ☐ Newspaper ☐ Yellow Pages ☐ Patient _____ Other _____

MEDICAL HISTORY

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

YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Cardiac Pacemaker
☐	☐	Heart Attack	☐	☐	Heart Murmur
☐	☐	Rheumatic Fever	☐	☐	Angina
☐	☐	Stroke	☐	☐	Tuberculosis
☐	☐	Prosthetic Heart Valve	☐	☐	Anemia
☐	☐	Asthma	☐	☐	Emphysema
☐	☐	Low Blood Pressure	☐	☐	Cancer
☐	☐	Epilepsy / Convulsions	☐	☐	Arthritis
☐	☐	Leukemia	☐	☐	Joint Replacement
☐	☐	Diabetes	☐	☐	Bleeding Problems
☐	☐	Kidney Diseases	☐	☐	Hepatitis: Type: _____
☐	☐	AIDS or HIV Infection	☐	☐	Sexually Transmitted
☐	☐	Thyroid Problem	☐	☐	Disease
☐	☐	Radiation Therapy	☐	☐	Sickle Cell Anemia
☐	☐	Heart Disease	☐	☐	Other _____

What drugs are you allergic to:

_____

What drugs are you currently taking?

_____

WOMEN:

Are you taking birth control meds? _____

Are you pregnant? _____

If Yes, How Long? _____

Names of Ob/Gyn: _____

Tel # _____

OFFICE USE ONLY

Medical History Update

Date	Normal	Change	Int.
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____

Physician's Name _____

Phone Number _____

Have you been hospitalized in the last 5 years? If YES, Why? _____

DENTAL HISTORY

YES	NO	
☐	☐	Are you having any discomfort at this time? Please specify _____
☐	☐	Have you been under regular care by a dentist? How long since your last dental visit? _____ What was done at that time? _____
☐	☐	Do your gums feel tender or swollen?
☐	☐	Are you aware of any lump or swelling in your mouth?
☐	☐	Are you anxious to keep your natural teeth?
☐	☐	Would you like whiter teeth?
☐	☐	Describe in your own words what you would like done with your teeth: _____

DO YOU CURRENTLY EXPERIENCE?

☐ loose teeth	☐ missing teeth
☐ sensitive teeth	☐ gagging
☐ ear ache	☐ unsatisfactory dentures
☐ headache	☐ pops / clicks in jaw joints
☐ sore gums	☐ spaced or crooked teeth
☐ bleeding gums	☐ bad breath

IF YOU ARE WEARING DENTURES OR PARTIALS:

a. How old are they? _____ years

b. Do you use denture adhesive? ☐ YES ☐ NO

Are you currently taking or have you ever taken any of these medications for osteoporosis or any type of cancer? Fosomax, etidronate, Boniva, Actonel, Skelid, IV administered meds such as Clodronate (bonefos,Clasteon,Ostac),Pamidronate(Aredia), zoledronic acid(Zometa or Aclasta)

SIGNATURE: I certify that I have read and understand the above Consent Information.

_____ _____

Patient, Parent, or Guardian Date