WELCOME

Date: ____________

Full Name: ____
Birth Date: ___________________ SSN: _______________________ Gender: M F
If child, parents name: ______________________________________
If married, Spouse's name: __________________________________

Home Address: ____
Home Phone: __________________ Work: _________________ Cell: _______________
Email Address: ____

How did you hear about our office? ____
____
Have any members or your family been seen in our office? ______________________
____

DENTAL HISTORY

How long since your last dental visit? ____

What is your reason for this visit? ____

Are you aware of any specific dental problems? ______________________________________
____
____

Are you currently in any pain? Y N

Are you happy with your smile? Y N If not, what would you change?
____
____
____
____

MEDICAL HISTORY

Please circle yes or no for each of the following that apply to you:

Y N – Allergy to Latex
Y N – Anemia
Y N – Artificial Joints
Y N – Blood Disease
Y N – Cancer
Y N – Currently Pregnant
Y N – Diabetes
Y N – Dizziness
Y N – Epilepsy/ Seizures
Y N – Excessive Bleeding
Y N – Fainting
Y N – Glaucoma
Y N – Heart Disease
Y N – Heart Murmur
Y N – Hepatitis
Y N – High Blood Pressure
Y N – HIV/AIDS
Y N – Pacemaker
Y N – Radiation Treatment
Y N – Stroke
Y N – Sinus Problems
Y N – Tuberculosis
Y N – Venereal Disease

DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED?
____
____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ______________________
____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: ____________
____
____

DO YOU HAVE ANY CONDITION THAT REQUIRES YOU TO BE PREMEDICATED WITH ANTIBIOTICS PRIOR TO DENTAL TREATMENT? YES OR NO ____________

EMERGENCY CONTACT PERSON: ____________________
TELEPHONE: ____________________

PATIENT/GUARDIAN SIGNATURE: ____________________