Welcome Patient and Dental/Medical Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Date _____/_____/_____

SS#_____ DL#_____

Patient Name_____ Nickname_____

Address_____ Apt.#_____ City_____

State_____ zip _____

Home ( )_____Cell ( ) _____ Work ( )_____ Ext____

Contacted Text Message ( ) No ( ) Yes

Contacted via email? ( ) No ( ) Yes, address_____

[ ] Minor/Child [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Sex [ ] M [ ] F Birth date_____ Age_____

Occupation_____

Name of School/Employer_____ Phone ( )_____

Address_____ Suite_____

City_____ State_____ Zip_____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____

Phone # ( ) _____ Relationship_____

If your are completing this form for another person, what is your relationship to that person?

Relationship_____

Your Name _____ Phone # ( )_____

PLEASE COMPLETE BACK SIDE OF FORM

Dental Information

Do your gums bleed when you brush or floss?..... ( ) Yes ( ) No ( ) Don't Know

Are your teeth sensitive to cold, hot sweets or pressure?..... ( ) Yes ( ) No ( ) Don't Know

Does food or floss catch between your teeth?..... ( ) Yes ( ) No ( ) Don't Know

Is your mouth dry?..... ( ) Yes ( ) No ( ) Don't Know

Have you had any periodontal (gum) treatments?..... ( ) Yes ( ) No ( ) Don't Know

Have you ever had orthodontic (braces) treatments?..... ( ) Yes ( ) No ( ) Don't Know

Are you currently experiencing dental pain or discomfort?..... ( ) Yes ( ) No ( ) Don't Know

Do you have earaches or neck pains?..... ( ) Yes ( ) No ( ) Don't Know

Do you have any clicking, popping or discomfort in the jaw?..... ( ) Yes ( ) No ( ) Don't Know

Do you have bruxism or grind your teeth?..... ( ) Yes ( ) No ( ) Don't Know

Do you have sores or ulcers in your mouth?..... ( ) Yes ( ) No ( ) Don't Know

Do you wear dentures or partials?..... ( ) Yes ( ) No ( ) Don't Know

Do you participate in active recreational activities?..... ( ) Yes ( ) No ( ) Don't Know

Have you ever had a serious injury to your head or mouth?..... ( ) Yes ( ) No ( ) Don't Know

What is the reason for your dental visit today?_____

How do you feel about your smile?_____

Date of your last dental exam?_____ What was done at that time_____

Date of your last x-rays_____

Medical Information

Are you now under the care of a physician? ( ) Yes ( ) No ( ) Don't Know

Physician Name:_____ Phone: ( )_____

Address/City/State/Zip:_____

Are you in good health? ( ) Yes ( ) No ( ) Don't Know

Has there been any change in your general health within the past year? ( ) Yes ( ) No ( ) Don't Know

If yes, what condition is being treated:_____

Date of last physical exam:_____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ( ) Yes ( ) No ( ) Don't Know

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ( ) Yes ( ) No ( ) Don't Know

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:_____

_____

Patient/Guardian Signature_____ ***Date***_____