Welcome

About You

Today's Date:_____/_____/_____

Name:_____ Male_____ Female_____
Last First M

Birthdate: _____/_____/_____ Social Security#: _____-_____-_____ Martial Status_____

Home Address:_____
Street City State Zip

Home Phone(_____)_____ Cell: (_____)_____ Work: (_____)_____

Whom may we Thank for referring you?_____

Employer Name:_____ Email Address:_____

EMERGENCY CONTACT:

Name_____ Relation:_____ Phone(_____)_____

Insurance Information

Dental Insurance Name:_____ Subscriber:_____
Subscriber ID Number:_____ Group Number:_____

Secondary Insurance Information

Dental Insurance Name:_____ Subscriber:_____
Subscriber ID Number:_____ Group Number:_____

Name: _____ Date of Birth: _____

HEALTH HISTORY

Anemia	Y	N	High Blood Pressure	Y	N
Arthritis, Rheumatism	Y	N	HIV Positive/AIDS	Y	N
Artificial Heart Valves	Y	N	Jaw Pain	Y	N
Artificial Joints	Y	N	Kidney Disease	Y	N
Asthma	Y	N	Liver Disease	Y	N
Abnormal Bleeding (after surgery)	Y	N	Mitral Valve Prolapse	Y	N
Cancer	Y	N	Pacemaker	Y	N
Chemical Dependency	Y	N	Psychiatric Care	Y	N
Chemotherapy	Y	N	Respiratory Disease	Y	N
Circulatory Problems	Y	N	Rheumatic Fever	Y	N
Congenital Heart Lesions	Y	N	Shingles	Y	N
Cortisone Treatments	Y	N	Shortness of Breath	Y	N
Cough, persistent or bloody	Y	N	Sinus Trouble	Y	N
Daytime Drowsiness	Y	N	Sleep Apnea	Y	N
Depression	Y	N	Stroke	Y	N
Diabetes	Y	N	Swelling of feet or ankles	Y	N
Emphysema	Y	N	Thyroid Problems	Y	N
Epilepsy/ Seizure	Y	N	Tobacco Use	Y	N
Dizziness or Fainting	Y	N	Tuberculosis	Y	N
Frequent Night -time Urination	Y	N	Ulcer	Y	N
Glaucoma	Y	N	Use CPAP?	Y	N
Headaches/Migraine	Y	N	Women:		
Heart Murmur	Y	N	Are you Pregnant?	Y	N
Heart Problems	Y	N	Are you Nursing?	Y	N
Hemophilia	Y	N	Other: _____		
Hepatitis Type_____	Y	N	_____		
Herpes	Y	N	_____		

Allergies:

Aspirin	Y	N	Latex	Y	N
Barbiturates	Y	N	Local Anesthetic	Y	N
Codeine	Y	N	Metals	Y	N
Erythromycin	Y	N	Penicillin	Y	N
Iodine	Y	N	Sulfa	Y	N
Jewelry	Y	N	Tetracycline	Y	N

Medications:

DENTAL HISTORY

Date of Last dental visit:_____/_____/_____ Previous Dentist:_____

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

Bleeding Gums	Y	N	Hot/Cold Sensitivity	Y	N
Bad Taste/Odor	Y	N	Hurt to Chew/Bite	Y	N
Cavities/Fillings	Y	N	Injury to Head/Neck/Jaw	Y	N
Clenching/Grinding of Teeth	Y	N	Lock Jaw	Y	N
Cold Sores/Ulcers	Y	N	Loose/Mobile Teeth	Y	N
Daytime Drowsiness	Y	N	Oral Cancer/Biopsy	Y	N
Deep cleanings/Scalings	Y	N	Orthodontic Treatment	Y	N
Difficulty Opening Jaw	Y	N	Pain in Ears/Temples/ Cheeks	Y	N
Frequent Headaches	Y	N	Sleep Apnea	Y	N
Gum/Periodontal Disease	Y	N	TMJ/TMD Joint Pain	Y	N
High Blood Pressure	Y	N	Wisdom Teeth Extraction	Y	N
Bisphosphonates	Y	N			

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

TMJ HISTORY			**SLEEP HISTORY**		
Jaw Pain	Y	N	Difficulty falling asleep or staying awake?	Y	N
Difficulty Opening/Closing Jaw	Y	N	Do you snore?	Y	N
Injury to Head/Neck	Y	N	Are you frequently tired during the day?	Y	N
Jaw Getting Stuck/Locked	Y	N	Do you stop breathing during sleep?	Y	N
Frequent Headache	Y	N	Are you irritable for no reason?	Y	N
Unexplained Head/Neck Pain	Y	N	Do you doze when reading, sitting, driving?	Y	N
Have you ever been treated for TMJ/TMD?	Y	N	Do you notice morning headaches?	Y	N

I understand that the information I have given today is correct and accurate to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize x-ray to be taken deemed necessary for diagnosis. I hereby authorize treatment and the use of nitrous oxide, oral sedation, and/or other medications necessary for dental treatment to be rendered by the dental staff.

Patient/Guardian Signature Date