Date: ____________

Patient Information

Patient Name ____________________ ____________________ Gender: __________
Last, First (Preferred Name)

Social Security #: __________ Birthdate: __________ Marital Status: __________

Phone (Home): __________ Work): __________ Ext: ______ (Cell) __________

Address: ____
Street **Apartment #**

____
City State Zip Code

Health Information

Date of Last Dental Visit: __________ Reason for this visit: __________

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies __________ __________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Blood Thinner
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur/Stents
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Bisphosphonates
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:__________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ **Codeine Allergy**
- ☐ **Penicillin Allergy**

Other

- ☐ __________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____________________
- Name of Physician: ____________________ Phone: __________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____________________

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____________________ Date: __________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐ **A**nother patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other

Name of person or office referring you to our practice: ____________________

Emergency Contact: ____________________ Relation __________

Contact Number ____________________

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment (Insurance Subscriber) ***If not same as above***

Employer Name: ______________________________ SS#_______________ DOB________________

PLEASE ANSWER THE FOLLOWING:

Question	Answer	Question	Answer
Do you snore?	☐ **Yes** ☐ **No**	Have you had Botox or any botulinum toxin injection in the past?	☐ **Yes** ☐ **No**
Does your partner tell you that you snore?	☐ **Yes** ☐ **No**	Are you interested in more youthful appearance with the use of Botox or dermal fillers such as Restylane or Juviderm?	☐ **Yes** ☐ **No**
Have you ever been diagnosed with sleep apnea?	☐ **Yes** ☐ **No**	Have you had any allergic reaction or adverse effects from botulinum toxin or dermal fillers?	☐ **Yes** ☐ **No**
Do you wake up with a dry mouth or sore throat?	☐ **Yes** ☐ **No**	Are you interested in straightening your teeth?	☐ **Yes** ☐ **No**
Do you use a CPAP or BiPAP?	☐ **Yes** ☐ **No**	Are you interesting in whitening your teeth?	☐ **Yes** ☐ **No**
Is it comfortable and are you able to wear it nightly?	☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**

Current Medications:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

I have provided as accurate and complete a medical and personal history as possible including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including X-rays.
I realize that despite the possible complications and risks, my recommended treatment is necessary and all reasonable options will be discussed. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees, warrantees, or representations have been made to me concerning the results of the procedure. Photographs may be taken before, during or after the procedures, for treatment planning or documentation purposes only; if taken they will be kept securely and privately.

Signature ____ Date____________________

Print Name ____ Date____________________