

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:

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

- 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 of 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.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another 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 _____

Medications

PLEASE ANSWER THE FOLLOWING

Do you snore?

Yes No

Have you ever been diagnosed with sleep apnea?

Yes No

Does your partner tell you that you snore?

Yes No

Do you wake up with a dry mouth or sore throat?

Yes No

Do you use a CPAP or BiPAP?

Yes No

Is it comfortable and are you able to wear it nightly?

Yes No

Have you had Botox or any botulinum toxin injection in the past?

Yes No

Are you interested in more youthful appearance with the use of Botox or dermal fillers such as Restylane or Juvederm?

Yes No

Have you had any allergic reaction or adverse effects from botulinum toxin or dermal fillers?

Yes No

Are you interested in straightening your teeth?

Are you interesting in whitening your teeth?

Yes No

Yes No

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 any and 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 in spite of the possible complications and risks, my recommended treatment is necessary. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the procedure.

Signature

Date