Personal Information

Name_____ Birth Date_____

Address_____

Postal Code_____ **E-Mail Address**:_____

Home Phone: (____)_____ Work Phone: (____)_____Cell Phone: (____)_____

Emergency Contact Name & Phone Number_____

Dental Insurance: Yes◯ No◯ Policy Holders Name _____ Date of Birth_____

If yes, Insur. Co. Name_____ Policy No._____ Cert. No._____

I authorize to have my insurance claims to be sent electronically. _____
(Signature)

Medical History

1. Are you presently under the care of a physician? Yes◯ No◯
2. Have you ever been hospitalized? Specify_____ Yes◯ No◯
3. Are you allergic to any medication? Specify _____ Yes◯ No◯
4. Are you allergic to latex? Yes◯ No◯
5. Are you presently taking any medications? Yes◯ No◯

Specify _____

6. Circle any of the following conditions, which you have had or have at present:

☐ Heart Murmur or other Heart Condition	☐ Hepatitis	☐ Stroke
☐ Stomach / Intestinal Problems	☐ Heart Attack	☐ Joint Replacement
☐ Mental or Nervous disorder	☐ Lung Disease / Asthma	☐ Cancer
☐ High / Low Blood Pressure	☐ Thyroid Disease	☐ Kidney Disease
☐ Epilepsy or Seizures	☐ Jaundice	☐ Liver Disease
☐ Arthritis	☐ Diabetes	☐ Sinus Trouble
☐ Scarlet or Rheumatic Fever	☐ Tuberculosis	☐ HIV
☐ Blood Disorder or Bleeding Problems	☐ Radiation Treatment or Chemotherapy	

☐ Other:_____

7. Have you ever had an injury, surgery or therapy to your face or jaws? Yes◯ No◯
8. Are you pregnant? If so what month are you in?_____ Yes◯ No◯
9. Do you smoke? If so, how much? _____ Yes◯ No◯

PLEASE NOTIFY US OF ANY CHANGES WHICH MAY OCCUR IN YOUR MEDICAL HISTORY

Dental History

Reason for today's visit: _____

Name of previous dentist: _____ Last dental visit:_____

Have you ever had a reaction to local anesthetic (freezing)? Yes◯ No◯

If yes, what was your reaction? _____

Do your gums bleed when brushing? Yes◯ No◯ flossing? Yes◯ No◯ Do they feel swollen? Yes◯ No◯

Do you think you have bad breath? Yes◯ No◯

Do you like the appearance of your teeth? Yes◯ No◯

Do you have trouble with your jaw? Specify_____ Yes◯ No◯

To the best of my knowledge I confirm that all information provided is true. _____
Patient Signature

_____
Date