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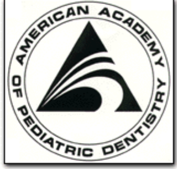
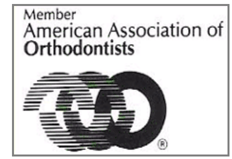


WELCOME!

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as completely as you can.
If you have questions we will be glad to help you.
We look forward to working with you in maintaining your dental health.

All questions contained in this questionnaire are strictly confidential
and will become part of your dental record.



Is there anything about you that we should know or consider before working with you?

Name (Last, First, MI): ☐ M ☐ F		**Today's Date** / /	
Email		**Date of Birth** / / **Age**	
Residence	**City**	**State**	**Zip**
Home Phone ( )		**Cell Phone** ( )	
Employer		**Telephone** ( )	
Employer's Address	**City**	**State**	**Zip**
Marital Status ☐ Married ☐ Divorced ☐ Single Parent ☐ Legal Guardian			
Children	☐ Yes ☐ No	**Names/Ages**	

Whom may we thank for referring you?	**Name**	**Phone**	
	Address		
	City	**State**	**Zip**

DENTAL HEALTH HISTORY

Date of last dental visit	/ /	**For what reason?**
Have you any dental problems?	☐ **YES** ☐ **NO**	**What problem?**
Have you had an unpleasant dental visit?	☐ **YES** ☐ **NO**	**Describe the experience.**
Have you any injuries to mouth, teeth or head?	☐ **YES** ☐ **NO**	**Describe the injury.**

Have orthodontic appliances ever been worn? ☐ YES ☐ NO

If yes, explain.

PLEASE CONTINUE TO PAGE 2

GENERAL HEALTH HISTORY

Physician's Name		**Telephone ( )**	
Address	**City**	**State**	**Zip**
Date of last exam / / Results:			

Are you taking any medication?	☐ Yes ☐ No	**What Medication?**
Do you have excessive bleeding when cut?	☐ Yes ☐ No	**Please Explain**
Have you ever been hospitalized?	☐ Yes ☐ No	**Please Explain**
Have you ever had surgery?	☐ Yes ☐ No	**Please Explain**
Are you allergic to any medication?	☐ Yes ☐ No	**Which ones?**
Are you allergic to latex?	☐ Yes ☐ No	
Any other allergies?	☐ Yes ☐ No	**What are They?**
Have you been under psychiatric care?	☐ Yes ☐ No	**Please Explain**

Do you have history of or difficulty with any of the following *(please check the box)*:

☐ ADD / ADHD	☐ Chronic sinus	☐ Eyes	☐ Hearing	☐ Malignancies	☐ Thyroid
☐ AIDS – HIV	☐ Cleft Lip/Palate	☐ Fainting	☐ High Fever	☐ Mononucleosis	☐ Tonsils / Adenoids
☐ Anemia	☐ Convulsions	☐ Heart	☐ Intestinal	☐ Rheumatic Fever	☐ Tuberculosis
☐ Asthma	☐ Diabetes	☐ Heart Murmur	☐ Kidney	☐ Skin	☐ Trauma to Face
☐ Canker Sore	☐ Epilepsy	☐ Headaches	☐ Liver	☐ Speech Disorder	☐

Please describe any current medical treatment, including drugs, pending surgery, recent injuries, or any other information we should be aware of that has not been discussed.

May we request the release of your medical records for our reference? ☐ Yes ☐ No

I understand that the information that I have provided is correct. It is my responsibility to inform this office of any changes in my medical status. I agree that I am responsible for payment.		Print Name Below
I give my permission for the staff to take dental X-rays of myself.	☐ **Yes** ☐ **No**	I authorize the dental staff to perform all necessary dental services on my behalf and to be responsible for payment of all dental services rendered on my behalf. Sign your name above to acknowledge your agreement.

IN CASE OF EMERGENCY

Name of relative or local friend	Relation to Patient	Home Phone	Work or Cell Phone

Thank you for completing our form!