|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Information (Please Print)** | | | | | Referred by | | | | | | | |
|  | | | | |  | | | | | | | |
| Patient Name (Last, First Middle) | | | | | | | | Birth date | | | | Age |
|  | | | | | | | |  | | | |  |
| Preferred Name / Nickname | | Email address | | | | | | Gender | | 🌕 Male 🌕 Female | | |
|  | |  | | | | | |
| Address | | | City | | | | State | | | | Zip | |
|  | | |  | | | |  | | | |  | |
| Mark which number is best to contact you | | | | | | | | | | | | |
| 🌕 Cell Phone | 🌕 Home Phone | | | | | 🌕 Work Phone | | | | | | |
|  |  | | | | |  | | | | | | |
| Employer | | | | | Occupation | | | | | | | |
|  | | | | |  | | | | | | | |
| Social Security # | | | | | Driver’s License | | | | | | | |
|  | | | | |  | | | | | | | |
| Emergency Contact Person | | | | | Phone | | | | | | | |
|  | | | | |  | | | | | | | |
| Family Physician | | | | | Phone | | | | | | | |
|  | | | | |  | | | | | | | |
| **Dental Insurance Information** | | | | | | | | | | | | |
| Name of Insurance | | | | | | | | | ID or Social Security # | | | |
|  | | | | | | | | |  | | | |
| Name of Insured (Primary) | | | | | | | | | Birth date | | | |
|  | | | | | | | | |  | | | |
| Employer | | | | | | | | | Work Phone | | | |
|  | | | | | | | | |  | | | |
| **Responsible Party** | | | | | | | | | | | | |
| Person Responsible for Payment | | | | | Relationship | | | | | | | |
|  | | | | |  | | | | | | | |
| Address | | | | City | | | State | | | | Zip | |
|  | | | |  | | |  | | | |  | |
| Phone | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Health History** | | | | | | | | | | | | |
| Are you happy with your Smile | | | | | 🌕 Yes 🌕 No | | | | | | | |
| If NOT, what would you change? | | | | | | | | | | | | |
|  | | | | | | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **Mark appropriate answer (Leave BLANK if you do not understand the question)** | | |
| **Yes** | **No** |  |
| 🌕 | 🌕 | Is your general health good? |
| 🌕 | 🌕 | Has there been a change in your health within the last year? |
| 🌕 | 🌕 | Have you had problems with prior dental treatment? |
| 🌕 | 🌕 | Are you in pain now? |
| 🌕 | 🌕 | Have you been hospitalized or had a serious illness in the last three years? |
|  |  | Why |
|  |  |  |
| 🌕 | 🌕 | Are you being treated by a physician now? |
|  |  | For what? |
|  |  |  |

**Health History (Continue)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Have you experienced** | | | | | | | | | | | | | | | | | | |
| **Yes** | **No** | | | | |  | | |  | | | | **Yes** | **No** | |  | | |
| 🌕 | 🌕 | | | | | Chest pain (angina) | | |  | | | | 🌕 | 🌕 | | Dizziness | | |
| 🌕 | 🌕 | | | | | Swollen ankles | | |  | | | | 🌕 | 🌕 | | Ringing in ears | | |
| 🌕 | 🌕 | | | | | Shortness of breath | | |  | | | | 🌕 | 🌕 | | Headaches | | |
| 🌕 | 🌕 | | | | | Recent weight loss, fever, night sweats | | |  | | | | 🌕 | 🌕 | | Fainting spells | | |
| 🌕 | 🌕 | | | | | Persistent cough, coughing up blood | | |  | | | | 🌕 | 🌕 | | Blurred vision | | |
| 🌕 | 🌕 | | | | | Bleeding problems, bruising easily | | |  | | | | 🌕 | 🌕 | | Seizures | | |
| 🌕 | 🌕 | | | | | Sinus problems | | |  | | | | 🌕 | 🌕 | | Excessive thirst | | |
| 🌕 | 🌕 | | | | | Difficulty swallowing | | |  | | | | 🌕 | 🌕 | | Frequent urination | | |
| 🌕 | 🌕 | | | | | Joint paint, stiffness | | |  | | | | 🌕 | 🌕 | | Dry mouth | | |
| 🌕 | 🌕 | | | | | Frequent vomiting, nausea | | |  | | | | 🌕 | 🌕 | | Jaundice | | |
| **Do you have or have you had** | | | | | | | | | | | | | | | | | |
| **Yes** | | **No** | | | | | |  | |  | | **Yes** | | **No** | |  | |
| 🌕 | | 🌕 | | | | | | Heart disease | |  | | 🌕 | | 🌕 | | AIDS or HIV | |
| 🌕 | | 🌕 | | | | | | Heart attack, heart defects | |  | | 🌕 | | 🌕 | | Tumors, cancer | |
| 🌕 | | 🌕 | | | | | | Heart murmurs | |  | | 🌕 | | 🌕 | | Arthritis, rheumatism | |
| 🌕 | | 🌕 | | | | | | Rheumatic fever | |  | | 🌕 | | 🌕 | | Eye disease | |
| 🌕 | | 🌕 | | | | | | Stroke, hardening of arteries | |  | | 🌕 | | 🌕 | | Skin diseases | |
| 🌕 | | 🌕 | | | | | | High blood pressure | |  | | 🌕 | | 🌕 | | Anemia | |
| 🌕 | | 🌕 | | | | | | TB, emphysema, other lung diseases | |  | | 🌕 | | 🌕 | | VD (syphilis or gonorrhea) | |
| 🌕 | | 🌕 | | | | | | Hepatitis, other liver disease | |  | | 🌕 | | 🌕 | | Herpes | |
| 🌕 | | 🌕 | | | | | | Stomach problems, ulcers | |  | | 🌕 | | 🌕 | | Kidney, bladder disease | |
| 🌕 | | 🌕 | | | | | | Allergies: to drugs, food medications | |  | | 🌕 | | 🌕 | | Thyroid, adrenal disease | |
| 🌕 | | 🌕 | | | | | | Family history of diabetes, heart problems, tumors | |  | | 🌕 | | 🌕 | | Diabetes | |
|  | |  | | | | | |  | |  | | 🌕 | | 🌕 | | Asthma | |
| **Do you have or have you had** | | | | | | | | | | | | | | | | |
| **Yes** | | | **No** | | | |  | |  | | **Yes** | | | **No** | |  |
| 🌕 | | | 🌕 | | | | Psychiatric care | |  | | 🌕 | | | 🌕 | | Hospitalization |
| 🌕 | | | 🌕 | | | | Radiation treatments | |  | | 🌕 | | | 🌕 | | Blood transfusions |
| 🌕 | | | 🌕 | | | | Chemotherapy | |  | | 🌕 | | | 🌕 | | Surgeries |
| 🌕 | | | 🌕 | | | | Prosthetic heart valve | |  | | 🌕 | | | 🌕 | | Pacemaker |
| 🌕 | | | 🌕 | | | | Artificial joint | |  | | 🌕 | | | 🌕 | | Contact lenses |
| 🌕 | | | 🌕 | | | | Mental handicap | |  | | 🌕 | | | 🌕 | | Eating disorder |
| 🌕 | | | 🌕 | | | | Organ transplant | |  | |  | | |  | |  |
| **Are you taking** | | | | | | | | | | | | | | | | |
| **Yes** | | | **No** | | | |  | |  | | **Yes** | | | **No** | |  |
| 🌕 | | | 🌕 | | | | Recreational Drugs | |  | | 🌕 | | | 🌕 | | Tobacco in any form |
| 🌕 | | | 🌕 | | | | Drugs, medicines, vitamins, supplements | |  | | 🌕 | | | 🌕 | | Alcohol |
| Please list drugs | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **Women ONLY** | | | | | | | | | | | | | | | | |
| **Yes** | | | **No** | |  | | | |  | | **Yes** | | | **No** |  | | |
| 🌕 | | | 🌕 | | Are you or could you be pregnant | | | |  | | 🌕 | | | 🌕 | Taking birth control pills | | |
| **All Patients** | | | | | | | | | | | | | | | | |
| **Yes** | **No** | | |  | | | | | | | | | | | | |
| 🌕 | 🌕 | | | Do you have or have had any other diseases or medical problems NOT Listed on this form? | | | | | | | | | | | | |
| If yes, Please list them | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |

To the best of my knowledge, I have answered every question completely and accurately. I will inform my Dentist of any change(s) in my health and/or medication.

|  |  |
| --- | --- |
| Patient / Guardian Signature | Date |
|  |  |
|  |  |