Name: _____ Today's date: _____ Birth date: _____

Address: _____ Marital Status: Married ❑ Single ❑ Other ❑

City: _____ Zip: _____ Telephone: Home _____ Business _____

Referred by: _____ Physician: _____

Person responsible for account: _____ Physician's address: _____

Occupation: _____ Physician's telephone: _____

Dental Insurance: _____ Former Dentist: _____

Date of last dental visit: _____ What was done for you at that time? _____

Are you aware of any particular dental problems? _____

Are you having any discomfort or pain? _____

How may we help you? _____

This personal information will help us render the best treatment for you. All information is, of course, confidential. Please check "YES" or "NO" or comment in the space provided.

	YES	NO
1. Has there been any problem in your general health within the past five years? (Serious illness, hospitalization, surgery, etc.) Please state: _____	❑	❑
2. Are you under a physician's care now?	❑	❑
3. What medications, tablets, pills or liquids do you take? (including aspirin, vitamins, tonics, etc.)		
Do you have or have you had any of the following diseases or problems:		
4. Rheumatic fever, rheumatic heart disease, heart murmur	❑	❑
5. Heart attack, heart trouble, high blood pressure, stroke	❑	❑
6. Pain in chest, shortness of breath, swollen ankles	❑	❑
7. Anemia, blood disorders, tire easily	❑	❑
8. Abnormal bleeding, prolonged healing, easily bruised	❑	❑
9. Asthma, hay fever	❑	❑
10. Low blood pressure	❑	❑
11. Fainting spells, seizures	❑	❑
12. Psychiatric treatment	❑	❑
13. Hepatitis, jaundice, liver diseases	❑	❑
14. Arthritis, painful joints, rheumatism	❑	❑
15. Kidney or bladder problems	❑	❑
16. Tuberculosis, other lung ailments	❑	❑
17. Persistent cough, cough up blood, vomit frequently	❑	❑
18. Venereal disease	❑	❑
19. Diabetes	❑	❑
20. Glaucoma, frequent eye problems	❑	❑
21. Frequent headaches, neck or shoulder pain	❑	❑
22. Frequent colds, sinus trouble	❑	❑
23. Earaches, hearing problems	❑	❑
24. Hives, skin rash, allergies	❑	❑
25. Ulcer, digestive problems, difficulty swallowing or chewing	❑	❑
26. Cancer, treatment for a tumor or growth	❑	❑
27. Injury to your face or jaws	❑	❑
28. Cold sores, canker sores, fever blisters, herpes	❑	❑
29. AIDS, HIV	❑	❑
30. *Please list any disease, condition or problem not mentioned above that you think the doctor should know about* _____		
Have you ever had an unusual reaction to any of the following drugs:		
31. Aspirin, Codeine or any analgesic (pain reliever)	❑	❑
32. Penicillin, or any antibiotic	❑	❑
33. Dental anesthetic (novocaine)	❑	❑
34. Iodine	❑	❑
35. Other medicines: _____		

	YES	NO
36. Are you dissatisfied with the appearance of your teeth?	❑	❑
37. Are you worried about receiving dental treatment?	❑	❑
38. When was the last time you had your teeth cleaned? _____ Full-mouth X-rays taken? _____		
39. Do your gums ever bleed, feel irritated, tender. or swollen?	❑	❑
40. Have you noticed any loose teeth?	❑	❑
41. Have you noticed any bad odors or tastes from your mouth?	❑	❑
42. Have you had a toothache recently?	❑	❑
43. Do you have any sensitive teeth? To what? Hot ❑ Cold ❑ Sweets ❑ Biting ❑ Chewing ❑	❑	❑
44.. Have you ever had periodontal (gum) treatment? Orthodontic (braces) treatment? When? _____	❑	❑
45. Have any of your teeth separated recently or does food tend to wedge between your teeth?	❑	❑
46. Do you have any missing teeth which have not been replaced?	❑	❑
47. When was the last time you had a tooth extracted? _____ Any associated problems?	❑	❑
48. Have you ever had trench mouth or Vincent's infection?	❑	❑
49. Is it difficult for you to open your mouth wide or does your jaw click when you chew or open wide?	❑	❑
50. Do you clench, grit, or grid your teeth in the daytime or while sleeping?	❑	❑
51. Do you awake with your teeth together or with a tired or tense feeling in your face or facial muscles?	❑	❑
52. Do you have any habits such as biting your nails, chewing on a pipe or pencil, etc.?	❑	❑
53. Have you been under more than average nervous tension recently?	❑	❑
54. List the oral hygiene aids used to clean your teeth and mouth and the frequency of their use. _____ _____		
55. Do you smoke or use smokeless tabacco? What and how much? _____	❑	❑
56. Would you be greatly disturbed if you had to lose all your teeth?	❑	❑
Women only, please answer the last two questions:		
57. Are you pregnant? If yes, what month? _____	❑	❑
58. Have you passed the menopause (change of life)?	❑	❑

(a) It is understood that appliances, models, radiographs, and photographs taken in the examination and treatment of dental problems remain the property of the dentist. (b) Consent is given to the taking and use of photographs for scientific and educational purpose.

Patient Signature _____