General Information Sheet

Welcome to our practice. So that we may provide you with the best possible care, please complete this form. All information is completely confidential.

Date _____
Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Fax _____
Pager _____
Cellphone _____

Employed by _____
Business Phone _____
Fax _____
E-Mail _____
Present position _____
How long held _____

Person responsible for account _____
If using Charge Card,
Name _____
Card no _____
Exp Date _____

Prefers to be called _____
Age _____
Date of Birth _____
Single _____ Married _____ Domestic Partner ___
SSN _____
Drivers License Number _____
E-Mail _____
Where should we confirm your appointments?
Phone Call _____ E-Mail _____

Spouse/Partner _____
Employed by _____
Business Address _____
Present Position _____
How long held _____

Dental Insurance

PRIMARY CARRIER
Insurance Company _____
Address _____
City _____ State _____ Zip _____
Tel _____ Group No _____
Employer Name _____
Insured's Name _____
Insured's Date of Birth _____
Relationship to Patient _____
Insured's I.D. No _____
Insured's SSN _____

SECONDARY CARRIER
Insurance Company _____
Address _____
City _____ State _____ Zip _____
Tel _____ Group No _____
Employer Name _____
Insured's Name _____
Insured's Date of Birth _____
Relationship to Patient _____
Insured's ID No _____
Insured's SSN _____

Closest Relative not living with you
_____
Phone Number _____
Address _____
City _____ State _____ Zip_____

Person to cantact for emergency
_____
Phone Number _____
Address _____
City _____ State _____ Zip _____

Is another member of your family or relative a patient at our office?
_____

You were referred to us by:
_____

Your former address:
City_____ State_____ Zip _____

Medical Information Sheet

Welcome to our practice. So that we may provide you with the best possible care, please complete this form. All information is completely confidential.

Patient Name _____

1. Name of Medical Doctor _____ Phone _____
   Last appointment with M.D. _____ Reason _____
   Address _____ City _____ State _____ Zip _____
2. Are you taking any over the counter, prescription or herbal medication, drugs or pills now? …….....…… Yes No
   If yes, please name the dosage _____
3. Have you ever had an allergic or adverse reaction to any or substance? ……..... Yes No

List medication _____
Describe medication _____

4. Have you ever had surgery or been hospitalized? ……..... Yes No
5. Have you ever pre-medicated for dental appointments? ……..... Yes No

Indicate which of the following have you had or currently have. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes No	Ulcers	Yes No	Hepatitis A or B	Yes No
High Blood Pressure	Yes No	Anorexia/Bulimia	Yes No	Hepatitis C	Yes No
Chest Pain	Yes No	Diabetes	Yes No	STD	Yes No
Congenital Heart Disease	Yes No	Thyroid Problems	Yes No	AIDS	Yes No
Heart Murmer	Yes No	Glaucoma	Yes No	HIV Positive	Yes No
Mitral Valve Prolapse	Yes No	Contact Lenses	Yes No	Cold Sores	Yes No
Artificial Heart Valve	Yes No	Emphysema	Yes No	Blood Transfusion	Yes No
Heart Pacemaker	Yes No	Chronic Cough	Yes No	Hemophilia	Yes No
Rheumatic Fever	Yes No	Tuberculosis	Yes No	Sickle Cell Disease	Yes No
Arthritis/Rheumatism	Yes No	Asthma	Yes No	Bruise Easily	Yes No
Cortisone Medication	Yes No	Hay Fever	Yes No	Liver Disease	Yes No
Swollen Ankles	Yes No	Latex Sensitivity	Yes No	Yellow Jaundice	Yes No
Stroke	Yes No	Sinus Trouble	Yes No	Epilepsy/Seizures	Yes No
Diet (Special/Restricted)	Yes No	Allergies or Hives	Yes No	Neurological	Yes No
Artificial (Hip, Knee)	Yes No	Radiation Therapy	Yes No	Disorder	Yes No
Kidney Trouble	Yes No	Chemotherapy	Yes No	Fainting/Dizzy Spells	Yes No
Psychiatric/Psychological Care	Yes No	Tumors/Cancer	Yes No	Nervous/Anxious	Yes No

6. Have you lost or gained more than ten pounds in the last year? ……...Yes No
7. Do you have any disease, condition, or problem not listed? ……Yes No
8. Women are you **Pregnant?**... Yes No **Nursing?**... Yes No **Taking Birth Control Pills?**....Yes No

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature _____ Date _____

Dental History Sheet

Welcome to our practice. So that we may provide you with the best possible care, please complete this form
All information is completely confidential.

Please list any dental problems or concerns _____
Date of Last Dental Visit _____Last Dental Cleaning _____ Last Full Mouth X-rays _____
What was done on your last dental visit? _____
Name of previous dentist _____
City _____ State _____ Telephone _____
How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
How often do you clean your tongue? _____
What type of manual toothbrush do you use? Soft Medium Hard
Do you (also) use an electric toothbrush? Sonicare Interplak Rotodent Other _____
What other dental aids do you use? _____
How often do you change your toothbrush? _____
What products are you currently using for breath control? _____

Are any of your teeth sensitive to:		
Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing	Yes	No
Have you noticed any mouth odor or bad tastes?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become Caught in between your teeth?	Yes	No
If yes, where? _____		

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
A bite plate or mouth guard?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No

Do you:		
Clench or grind your teeth?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Bite your lips or cheek regularly?	Yes	No
Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)?	Yes	No
Smoke/Chew tobacco?	Yes	No
Would you like information on how to control halitosis (bad breath)?	Yes	No
If there was a simple, easy way to whiten your teeth, would you be interested?	Yes	No
Would you like to know more about options for improving your smile?	Yes	No

Have you ever experienced:		
Sore muscles (neck and shoulders)?	Yes	No
Clicking or popping of the jaw?	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
A serious injury to the mouth or head?	Yes	No

Are you satisfied with the appearance of your teeth?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern? _____
Have you ever had an upsetting dental experience?
If yes, please describe: _____

Is there anything about having dental treatment that you would like us to know?	Yes	No

If yes, please describe: _____