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Welcome to our office. Please fill out all that apply to you.

Personal Information

_____
Last Name First Name MI Preferred Name

☐Female ☐Male ☐Married ☐Single ☐Child ☐Other

_____ _____ _____
Birth date SS# Referred By:

_____
Email Address

_____ _____ _____
Home Phone Work Phone Mobile Phone

_____
Address

_____ _____
Emergency Contact Name Emergency Contact Phone

_____ _____
Employer Name Employer Phone

_____
Employer Address

Medical History

_____ _____
Physicians Name Physicians Phone

_____
Date of last Physician Visit

Please check all that apply to you:

☐ Require Pre-Medication (please list antibiotic) _____

☐ Artificial Joints	☐ Allergies (Please list below)
☐ Birth Control	☐ Anemia
☐ Coumadin	☐ Xarelto
☐ Aspirin Daily	☐ Arthritis
☐ Epilepsy	☐ Blood Disease
☐ Glaucoma	☐ Diabetes
☐ Heart Murmur	☐ Excessive Bleeding
☐ High Cholesterol	☐ Hepatitis
☐ Kidney Disease	☐ HIV
☐ Nervous Disorders	☐ Liver Disease
☐ Pacemaker	☐ Nexium/Prilosec/Omep
☐ Respiratory Problems	☐ Pregnancy
☐ Sinus Problems	☐ Rheumatic Fever
☐ Tuberculosis	☐ Stomach Issues
☐ Venereal Disease	☐ Tumors
☐ Asthma	☐ Cancer
☐ Dizziness	☐ Fainting
☐ Heart Disease	☐ High Blood Pressure
☐ Jaundice	☐ Mental Disorders
☐ Radiation Treatment	☐ Rheumatism
☐ Stroke	☐ Ulcers

☐ Other_____

_____

_____

Please List all allergies:_____

_____

_____

Please list ALL medications:_____

_____

_____

Dental History

_____
Reason for Today's Visit

_____
Former Dentist Name & Phone

How often do you brush? ☐3+times/day ☐2times/day ☐1time/day ☐Occasionally

How often do you floss? ☐Never ☐Occasionally ☐Weekly ☐Daily

Please check the boxes that apply to you:

☐Head or neck injuries
☐Sensitive teeth to hot
☐Sensitive teeth to sweets
☐Sensitive teeth to cold
☐Gums swollen or tender
☐Grind or clench teeth
☐Dry Mouth
☐Food collection between teeth
☐Gag easily
☐Other _____

☐Bleeding Gums
☐Loose or broken teeth
☐Sores on lips/mouth
☐Chew only on one side
☐Anxiety of dental care
☐Clicking or popping jaw
☐Difficulty chewing
☐Orthodontic treatment
☐Stained teeth