



New Patient Personal and Medical History

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Hm Phone: _____ Cell: _____ Work: _____

DOB: _____ Social Security # _____ - _____ - _____ Marital Status: S ___ M ___ D ___ W ___ P ___

Email: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

MEDICAL HISTORY: Physician's Name: _____

Are you currently undergoing any medical treatment or seeing a physician for a particular problem? If so, please explain:

Have you had any hospitalizations or surgeries? If so, please explain:

Please list any prescription medications you are taking:

Please list any over-the-counter medications or herbal products you are taking:

Are you allergic to or have you had a bad reaction to any medications or products below:

Penicillin _____ Aspirin _____ Codeine _____ Sulfa _____ Iodine _____ Latex _____

Sedatives _____ Anesthetics _____ Food: _____

Other: _____

Are you currently pregnant or trying to get pregnant? _____ # of week? _____

Are you experiencing any symptoms of menopause or premenopause?

Do you smoke or use any smokeless tobacco products? If so, how long?

Have you smoked in the past? If so, how long did you and how long since you have quit?

DO YOU or HAVE YOU had any of the following:

- | | |
|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer/Leukemia |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Heart Valves Replaced | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Previous Bacterial Heart Infection | <input type="checkbox"/> Bone Disorders |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Hormone Replacement Therapy |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Human Papilloma Virus (HPV) |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Herpes/Cold Sores |
| <input type="checkbox"/> Shunt placed | <input type="checkbox"/> Hay Fever/Seasonal Allergies |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Autism |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Bulemia |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anorexia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |

TELL US ABOUT YOUR TEETH...

When was your last dental visit? _____ Any treatment needed then? _____

Do you have sensitivity to hot/cold? _____ Chewing Pain? _____

Have you had any head, neck, or jaw injuries? _____

Does your jaw hurt when you open/close your mouth? _____

Does it click, pop, or lock? _____

Do you have headaches? If so, how often? _____

Have you had braces? _____ Number of years in braces? _____

Are you interested in Tooth Whitening? _____

ANY OTHER DENTAL CONCERNS YOU HAVE OR WORK YOU WANT COMPLETED?

Authorization and Release:

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practioners. I agree to be responsible for payment of all services rendered on my behalf or my independents.

X _____
Signature of patient or parent if minor

_____/_____/_____
Date