

New Patient Medical / Dental History

Medical History

(This information will be held in strict confidence)

Date *	Name *	Preferred Name	Gender *	
Month Day Year	First Name Last Name			
Marital Status	Spouse's Name	Address *		
		Street Address		
		City	State / Provi	nce
		Postal / Zip Code		
Home Phone Number	Work Phone Number	Cell Phone Number *		Email *
Please enter a valid phone number.	Please enter a valid phone number.	Please enter a valid phone numb	er.	example@example.com

Emergency Contact

Emergency Contact Name * Emergency Contact Phone Number * Referred By

Please enter a valid phone number.

Dental Questionnaire

Yes

No

Date of most recent dental visit Does dental treatment make you nervous? * My mouth is * No Somewhat Very comfortable Moderately Comfortable Extremely Uncomfortable Month Day I think the appearance of my mouth is * Excellent Satisfactory Unsatisfactory Do you use the following? * If "Other" Please Explain * How often do you brush? **Dental Floss** Toothbrush Other **Oral Irrigator** Do you use a soft toothbrush? * Have you ever been treated for periodontal disease (gum Yes No disease)? * Yes No Do you have, or have you ever experienced the following? Unpleasant Taste / Bad Breath * Frequent Mouth Blisters * Bleeding, Sore Gums * **Burning Tongue / Lips ***

Yes No Yes No Yes No Yes No Swelling / Lumps in Mouth * Orthodontic Treatment (Braces) * Biting Cheeks / Lips * Clicking / Popping Jaw * No Yes Yes No Yes No Yes No Biting Sensitivity * Loose Teeth * Sensitive to Hot * Sensitive to Cold * Yes No Yes No Yes No Yes No Clenching / Grinding * When? * Food Impaction * Shifting in Bite * Yes Yes No Yes No No If "Yes" Please Explain * Are you having any discomfort at These are the things that are important to me regarding my dental health * this time? Yes No

Health Questionnaire



Are you allergic OR have you reacted adversely to

Aspirin
Penicillin or other antibiotics
Codeine or other analgesic

If "Allergies to other meds" Please Explain *

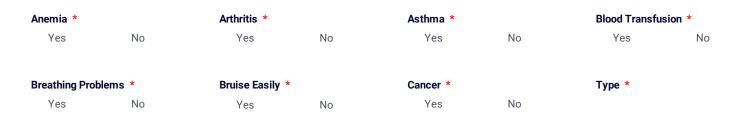
Sulfa drugs
Lodine
Local Anesthetics
Local Anesthetics

Local Anesthetics

Local Anesthetics

Local Anesthetics

Do you have, or have you had, any of the following?



Chemotherapy *		Chronic Fatigu	Chronic Fatigue Syndrome *		Cold Sores / Fever Blisters *		Diabetes *	
Yes	No	Yes	No	Yes	No	Yes	No	
Do you take Insulin? *		Drug Addiction	Drug Addiction *		Emphysema *		Environmental Sensitivities *	
Yes	No	Yes	No	Yes	No	Yes	No	
Epilepsy or Seizures *		Epstein Barr V	Epstein Barr Virus *		Excessive Bleeding *		Fibromyalgia *	
Yes	No	Yes	No	Yes	No	Yes	No	
Frequent Headaches *		Hearing / Visio	Hearing / Vision Loss *		Hemophilia *			
Yes	No	Yes	No	Yes	No			
Hepatitis *		Type *		Herpes *		High Cholesterol *		
Yes	No	A C	В	Yes	No	Yes	No	
Hives / Skin Rash *			Joint Pain / Inflammatory		Joint Replacement *		If "Yes" Please Explain *	
Yes	No	Yes	No	Yes	No			
Kidney Problems *		Lung Disease	Lung Disease *		Multiple Chemical Sensitivity *		Psychiatric Care *	
Yes	No	Yes	No	Yes	No	Yes	No	
adiation *		Sexually Transmitted Disease *		Stroke *		Thyroid Disease *		
Yes	No	Yes	No	Yes	No	Yes	No	
obacco *		Type *		How Often? *	How Often? *		Tuberculosis *	
Yes	No					Yes	No	
		Vertigo *						
llcers *		Yes						

Congenital Heart Lesions		Rheumatic Fe	Rheumatic Fever		High Blood Pressure		Low Blood Pressure	
Yes	No	Yes	No	Yes	No	Yes	No	
Irregular Heart Beat		Cardiovascula	r Disease	Heart Murmur		Mitral Valve P	rolapse	
Yes	No	Yes	No	Yes	No	Yes	No	
Do you have a	pacemaker?	Are you on blo	od thinners?					
Yes	No	Yes	No					

WOMEN

 Pregnant
 Nursing
 Taking oral contraceptive

 Yes
 No
 Yes
 No

 Signature
 Name of Patient, Parent or Guardian

 First Name
 Last Name
 Month
 Day
 Year