

Health and Dental History
(please print)

Patients Name: _____ Address: _____

I prefer to be called: _____ Address cont'd: _____

Home phone: _____ Cell phone: _____ Work phone: _____

SSN: _____ Date of Birth: _____ E-Mail: _____

Physician's Name: _____ Phone number: _____

Are you taking any medication now, including regular dosages of aspirin? Yes No

If so, please list name and dosage _____

Are you aware of having an allergic reaction to any medication or substance? Yes No

If so, please list _____

Have you been under the care of a medical doctor during the past two years? Yes No

If so, for what _____

Have you seen an ENT (ear, nose, throat doctor)? Yes No Name: _____

Have you seen a chiropractor? Yes No Name: _____

Have you seen a neurologist? Yes No Name: _____

Have you had braces Yes No Name: _____

Indicate which of the following you have had, or have at present. Circle "yes" or "no" for each item

Heart Concerns	Yes No	Headaches	Yes No	Does floss shred when you use it?	Yes No
Congenital Heart Disease	Yes No	Jaw Pain	Yes No		
Hear Murmur	Yes No	Jaw Popping	Yes No		
High Blood Pressure	Yes No	Limited Opening	Yes No	Does food pack or catch between	Yes No
Mitral Valve Prolapse	Yes No	Congested Ears	Yes No	your teeth?	Yes No
Artificial Heart Valve	Yes No	Dizziness	Yes No		
Pacemaker	Yes No	Ringing Ears	Yes No	Do you smoke or chew tobacco?	Yes No
Stroke	Yes No	Loose Teeth	Yes No		
Asthma	Yes No	Posture Problems	Yes No		
Liver Disease/Jaundice	Yes No	Clenching	Yes No	Do your gums bleed?	Yes No
Latex Sensitivity	Yes No	Grinding	Yes No		
Artificial Joints	Yes No	Facial Pain	Yes No		
Kidney Trouble	Yes No	Sensitive Teeth	Yes No	Does your breath concern you?	Yes No
Radiation/Chemotherapy	Yes No	Neck Ache	Yes No		
Epilepsy/Seizures	Yes No	Bell's Palsy	Yes No		
Diabetes	Yes No	Difficulty Swallowing	Yes No	Would you like whiter teeth?	Yes No
Hepatitis	Yes No	Difficulty Chewing	Yes No		
AIDS/HIV	Yes No	Trigeminal Neuralgia	Yes No		
Sickle Cell Disease	Yes No	Tingling in Arms/Fingers	Yes No		
Neurological Disorders	Yes No	Insomnia	Yes No		
Psychiatric/Psychological Issues	Yes No	Alcohol/Drug Abuse	Yes No		

Do you have or have you had any disease or problem not listed? _____

Women: Are you: Pregnant? _____ Nursing? _____ Taking birth control pills? _____

I understand 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 who may release such information to you. I will notify the doctor of any change in my health or mediations.

Signature: _____ Date: _____

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Our office may be unlike any other dental office you have visited. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Here are some things we are going to be talking about at your first visit. These are issues you may have never thought about. Please check what best expresses how you feel about the following questions.

- Do you have any areas of concern? _____
- What do you think the present state of the health of your mouth is? _____
- Do you have any friends or family that already come to our office? _____
- How did you hear about our office? _____

- How healthy do you want us to get your mouth? (please circle)
 Don't really care Average The best it can be

- Should you need treatment, at what point should we address it? (please circle)
When my tooth hurts or breaks When something is worsening When something isn't ideal

- What quality of dentistry do you want us to recommend?
/ Just patch it Average Ideal/The Best

- We have the ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you? (please circle)
 As a **restorative** dentist As a **cosmetic** dentist As a **functional** dentist

- Is there anything you would like to change about the appearance of your smile? _____
- When was your last dental visit or appointment? _____
- Tell us about your good dental experiences _____
- Any bad dental experiences? _____
- Has fear ever been an issue for you in a dental office? _____
- What caused you to leave your last dental office? _____

Is there any additional information you would like us to know? _____

Employer: _____ How long there: _____ Occupation: _____

Insurance Information

Insurance Co. Name: _____ Phone #: _____

Insured's Name: _____ Insured's SSN: _____

I understand that this office does accept insurance benefits for primary insurance only. We will gladly assist you to maximize your dental benefits, however we ask that you pay the estimated non-covered balance at the time of service. I also understand that my insurance policy is an agreement between the insurance company and myself, therefore I am ultimately responsible for all fees incurred for my dental treatment.

Our office accepts Visa, MaserCard, cash and personal check. We have also arranged for interest free financing, and payment plans for up to 60 months with Care Credit

Signature of patient

Date