PATIENT HISTORY AND INFORMATION

Patient: _____ Date of Birth.: _____ / _____ / _____
(Last) (First) (Middle Initial) (Day) (Month) (Year)

If Patient is a minor, who is legally responsible? _____

Address: _____ City: _____

Postal Code: _____ Tel: (Res.) _____ (Bus.) _____ Cell Phone _____

Email: _____ Employer: _____ Physician: _____

Family Dentist: _____ Referred by (if other than dentist): _____

Primary Insurance Dental Insurance Co. _____ Policy or Group # _____ I.D. or Cert. # _____

Secondary Insurance Dental Insurance Co. _____ Policy or Group # _____ I.D. or Cert. # _____

Spouse's name _____ Date of Birth _____ Spouse's Employer _____

MEDICAL HISTORY

1. Has there been any change in your general health within the past year? ❑ No ❑ Yes

   If "YES", please specify _____

2. Are you under the care of a physician for a current problem? ❑ No ❑ Yes

   If so, describe nature of treatment _____

3. Are you taking any prescription medicines or non-prescription drugs (i.e. aspirin, herbal medications, etc.) of any kind? ❑ No ❑ Yes

   If so, please specify _____

4. Are you taking any medications for your tooth? ❑ No ❑ Yes

   If so, please specify _____

5. Have you had abnormal bruising or bleeding with previous extractions, surgery, or trauma? ❑ No ❑ Yes

6. Have you had any ALLERGIC or ADVERSE REACTIONS to anesthetics, latex, antibiotics, or other medications? ❑ No ❑ Yes

   If so, please specify _____

7. Do you smoke tobacco? ❑ No ❑ Yes

8. Do you have, or have you had, any of the following (if yes, please check):

❑ Congenital Heart lesions	❑ Jaw joint problems	❑ Kidney problems
❑ Heart Murmur or Prolapsed Valve	❑ Asthma or Hay fever	❑ Radiation treatment
❑ Rheumatic fever or Rheumatic heart disease	❑ Blood disorders (e.g. anemia)	❑ Reactions to dental 'freezing'
❑ Prosthetic Heart valve	❑ Colitis	❑ Sinus trouble
❑ Cardiovascular disease: heart attack, stroke, by-pass	❑ Diabetes	❑ Surgery
❑ Artificial Joints	❑ Epilepsy, seizures, fainting	❑ Thyroid problems
❑ High Blood Pressure	❑ Jaundice, Liver disease	❑ Tumors or Growths
❑ Pacemaker	❑ HIV / AIDS	❑ Ulcer
❑ Allergies	❑ Nervous disorders	❑ Respiratory disease
❑ Hepatitis A, B, or C		

9. Do you have any disease, condition or problem not listed above? _____ ❑ No ❑ Yes

10. Does your physician ALWAYS require you to take antibiotics prior to dental treatment? _____ ❑ No ❑ Yes

11. Women: Are you pregnant? ❑ No ❑ Yes Due Date: _____ Are you breast feeding? ❑ No ❑ Yes

12. Do you take birth control pills? ❑ No ❑ Yes If YES, be advised that if you take antibiotics, an alternate method of birth control must be used.

SIGNATURE: _____ DATE: _____

Please answer the following 7 questions:

1. Are you presently having pain? ❑ Yes ❑ No ❑ Other _____
2. When did the pain start? _____
3. When does it hurt? Circle: cold / heat / chewing / sweet / BY ITSELF / other _____
4. Which of the following would describe your pain? Circle: mild / moderate / severe / sharp shooting / dull throb / continuous / intermittent / other
5. If cold hurts your tooth, when the cold is removed, does the pain linger? ❑ Yes: how long? _____ ❑ No
6. On a scale of 1 - 10 (10 being the worst) how would you rate your pain? _____
7. Are you aware of clenching and/or grinding your teeth? ❑ No ❑ Yes