Medical History

Physician's Name _____ **Phone** _____

Physician's Address _____ **City** _____ **State** _____ **ZIP** _____

Currently under a Physician's care? No ❑ Yes ❑ If so, why? _____

_____

Please check the appropriate items. A blank box indicates you have never had that specific problem or condition.

Has patient ever had a problem with, treatment for, or diagnosed with the following:

❑Osteoporosis	❑Hepatitis or Jaundice	❑HPV	❑Tuberculosis
❑Joint replacement	❑Liver disease	❑Diabetes	❑Asthma
❑Artificial Heart Valves	❑Bleeding disorder	❑Kidney	❑Thyroid problems
❑Congenital Heart Disease	❑Anemia	❑Tumor or Growth	❑Arthritis or Rheumatism
❑Stroke	❑Leukemia	❑Cancer	❑Back Problems
❑Infective Endocarditis	❑Ulcers/Reflux	❑Chemotherapy	❑Glaucoma
❑Pacemaker	❑HIV positive	❑Hives or severe rash	❑Sinus trouble
❑Heart Problems(describe below)	❑High Blood Pressure	❑Skin problems	❑Chemical dependency
❑Abnormal bleeding after extraction or surgery	❑Cortisone treatments	❑Epilepsy	❑Seizures
	❑Tobacco	❑Daily Alcohol	❑Other_____

Please describe checked items:

_____

_____

Allergies to:

❑Penicillin	❑Iodine	❑Tetracycline
❑Codeine	❑Nickel	
❑Aspirin	❑Sulfa drugs	
❑Local Anesthetics	❑Other _____	

Women:

Are you pregnant? _____ due date ___/___/___-

Taking Birth Control Pills?_____

Please list all medications you are currently taking (include dose and frequency):

_____

_____

_____

List operations that you have had:

_____

_____

_____

The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I will not hold my dentist or any member of his/her staff responsible for any error or omissions that I have made in the completion of this form. _____**initial**

I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers (e.g. insurance co.) and/or health practitioners. _____**initial**

I understand that my dental insurance carrier may pay less than the estimated amount for services. _____**initial**
I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____ **DATE** _____

Welcome!

Patient Information

*Patient Name*_____ *Nickname*_____ *SS#*_____

*Birthday*_____ *Sex: M___ F___* *Single____ Married____ Widowed____Divorced____ Separated____*

*Patient Address*_____ *City*_____ *State*_____ *Zip*_____

Cell Phone _____ *Parents Names (if minor)* _____

Work Phone _____ *Best Phone Number & Time of Day to Call* _____

Home Phone _____ Email Address _____

Patient Employer _____ *Position* _____

Spouse Name _____ *Spouse Birthday* _____ *SS#* _____

Spouse Employer _____ *Spouse Work Phone* _____

Spouse's Cell Phone _____ *Email*_____

How did you hear about our office? _____

Responsible Party, if other than self

Name of Person Responsible for this Account _____ *Relationship to Patient* _____

Address _____ *City* _____ *State* ____ *Zip* _____

SS# _____ *Birthday* _____ *Employer* _____ *Work Phone Number* _____

Is this Person Currently a Patient in our office? _____ *Cell Number*_____ *email*_____

Consent to ELECTRONIC COMMUNICATION I authorize this facility along with any Billing Service, Collection Agency, or Attorney who may work on their behalf to contact me on my cellphone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices, or other computer-assisted technology, or by E mail, TEXT messaging, or by any other means of electronic communication. SIGNATURE: _____ DATE: _____

Dental History

Name and address of former Dentist _____ *Date last seen* _____

What was done? _____ *Date of last FULL MOUTH X-Rays* _____

*Reason for today's visit*_____

Has your experience of dental treatment in the past been: good □ bad □ Describe: _____

_____

Have you noticed:

□ *Gums bleed or hurt while brushing*
□ *Loosening of permanent teeth*
□ *Food gets caught between teeth*
□ *Teeth sensitive to hot, cold, or sweets*
□ *Grinding teeth while asleep*
□ *Squeezing or clenching teeth*
□ *Frequent headaches*
□ *Pain in jaw joint*
□ *Popping or Clicking of Jaw Joint*
□ *Sores or lumps in or near the mouth*
□ *Other, Describe* _____

Are you satisfied with the appearance of your teeth and smile? _____

Have you been told you Snore? _____
Do you fall asleep at inappropriate times (at work, driving, etc)? _____
Do you frequently fall asleep while sitting in a chair, or watching TV, or reading? _____
Would you like to know more about Anti-Snoring Mouthpieces for yourself or another person? _____

Please check which are most important to you

□ *Your appearance*
□ *Most economical*
□ *Comfort (free from mouth pain)*
□ *Saving time*
□ *Other* _____