In order to help you reach and maintain your maximum oral health, please fill out the following information. As always, our goal is to care for a lifetime of smiles. All information is confidential.

TODAYS DATE ___/___/___

About You:

NAME______________________________SPOUSE__________________________________

ADDRESS__Street____

__City______________________________ Zip______________________________

PHONE___Home __________________ Cell ________________________ Work________________________

EMAIL ____

SOCIAL SECURITY # ______________________ BIRTHDAY_________/_________/______________________

EMPLOYER ________________________________POSITION__________________________________

WHOM MAY WE THANK FOR REFERRING YOU?____

Dental Insurance:

NAME OF INSURED PERSON____

EMPLOYER (INSURED PERSON)____

SOCIAL SECURITY # ______________________________BIRTHDAY__________/_________/_______________

INSURANCE COMPANY NAME____

INSURANCE COMPANY ADDRESS____

____

GROUP # (plan, local or policy #)____

Secondary Insurance:

NAME OF INSURED PERSON____

EMPLOYER (INSURED PERSON)____

SOCIAL SECURITY # ______________________________BIRTHDAY__________/_________/_______________

INSURANCE COMPANY NAME____

INSURANCE COMPANY ADDRESS____

____

GROUP # (plan, local or policy #)____

MEDICAL HISTORY

Name of Physician ______________________________

PLEASE LIST ANY PRESCRIPTIONS/OVER-THE-COUNTER DRUGS YOU ARE NOW TAKING

____
____
____
____

Have you ever had any of the following diseases or medical problems?

Circle the appropriate answer

Y N HEART ATTACK / STROKE

Y N HIGH / LOW BLOOD PRESSURE

Y N HEART MURMUR / MITRAL VALVE PROLAPSE

Y N HEART SURGERY / PACEMAKER

Y N HEART DEFECT

Y N ARTIFICIAL BONES / JOINTS

Y N ULCERS / COLITIS

Y N DIABETES

Y N EMPHYSEMA

Y N COLD SORES / HERPES

Y N HEPATITIS

Y N HIV + / AIDS

Y N HEMOPHILIA / ABNORMAL BLEEDING

Y N ASTHMA / HAY FEVER

Y N DRUG / ALCOHOL ABUSE

Y N EPILEPSY / SEIZURES ./ FAINTING SPELLS

Y N SINUS PROBLEMS

Y N CANCER

Y N CHEMOTHERAPY / RADIATION TREATMENT

WOMEN ONLY

Y N ARE YOU PREGNANT? DUE DATE: ______________________

Y N ARE YOU NURSING?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

CIRCLE ANY THAT APPLY

PENICILLIN, ASPIRIN, IBUPROPHEN, ERYTHROMYCIN, TETRACYCLINE, DENTAL ANESTHETICS, LATEX, CODEINE

ANY OTHER ITEMS NOT MENTIONED ?______________________________
____
____

ANY CONDITIONS NOT LISTED THAT THE DOCTOR SHOULD KNOW ABOUT? ______________________
____

SIGNATURE ______________________________

THANK YOU!

DO NOT FILL OUT THIS PAGE

OFFICE USE ONLY

HOW LONG HAS IT BEEN SINCE YOUR LAST REGULAR DENTAL VISIT?________________

HOW OFTEN DO YOU BRUSH YOUR TEETH?_______________
FLOSS?__________________

TYPE OF BRUSH? HARD MEDIUM SOFT

ANY AREAS OF YOU GUMS THAT BLEED REGULARLY? Y N ________________________

ARE YOUR TEETH SENSITIVE TO: SWEET HOT COLD ______________________________

____

ARE THERE ANY TEETH YOU CAN'T CHEW ON OR PUT PRESSURE ON? Y N

____

DO YOUR GUMS GET TENDER OR SWOLLEN ON A REGULAR BASIS? Y N

____

DO YOU CLENCH OR GRIND YOUR TEETH Y N NIGHT DAY

____

DO YOUR JAWS? POP CLICK RIGHT LEFT PAIN Y N CATCH Y N

____

DO YOU WEAR ANYTHING THAT IS REMOVABLE? Y N

____

IS THERE ANYTHING THAT WE DIDN'T MENTION THAT YOU WOULD LIKE TO CHANGE OR IMPROVE ABOUT YOUR SMILE/APPEARANCE_______________________________________

____

____

NOTES____

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____ SAN 9/08