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Welcome To Our Practice

Please Print Clearly

Date_____

Patient (Mr., Mrs., Ms., Dr.) First Name_____M.I._____Last Name_____

Zip Code_____Address_____City_____State_____Hm#_____

Wk# _____Ext_____Employer_____D.O.B._____Age_____Weight_____

Sex ○ Male ○ Female Social Security #_____Marital Status_____Drivers License #_____

Dentist_____Physician_____Referred By_____

Who will be responsible for your account? ○ Self ○ Spouse ○ Father ○ Mother ○ Other_____ Responsible Party's DL#_____

Spouse's Name_____Employer_____Wk#_____SS#_____

Father's Name_____Zip_____Address_____City_____State_____

Hm#_____Employer_____Wk#_____D.O.B._____SS#_____DL#_____

Mother's Name_____Zip_____Address_____City_____State_____

Hm#_____Employer_____Wk#_____D.O.B._____SS#_____DL#_____

Have you or a family member ever been a patient of our practice? ○ Yes ○ No Whom_____When_____

Do you have insurance? ☐ Dental ☐ Medical Alternate or Cell Phone #_____

Reason for today's office visit?_____

PERSONAL HEALTH QUESTIONAIRE (Please Check Yes or No)

1. ○ Yes ○ No Are you in good general health_____
2. ○ Yes ○ No Are you presently under a physician's care_____
3. ○ Yes ○ No Have you had any operations, general anesthetics, blood transfusions, or hospitalizaions_ (Please list)

_____

_____

4. ○ Yes ○ No Have you been taking any medicines, herbs or drugs now or within the past year? (Including birth control pills)

MEDICINE	DOSAGE	HOW OFTEN	MEDICINE	DOSAGE	HOW OFTEN

5. List any medication that you are allergic to or had a bad reaction to_____

_____

HAVE YOU HAD OR EVER SUSPECTED ANY OF THE FOLLOWING CONDITIONS (Please Check Yes or No)

○ Yes	○ No	Cancer	○ Yes	○ No	Kidney or Bladder Trouble
○ Yes	○ No	Heart Disease (Please Circle)_ Rheumatic Fever	○ Yes	○ No	Diabetes
		Heart Murmur, Chest Pain, Heart Attack, Stroke,	○ Yes	○ No	Stomach Ulcers
		Shortness of Breath, Ankle Swelling	○ Yes	○ No	Seizures
○ Yes	○ No	High Blood Pressure	○ Yes	○ No	Arthritis or Joint Pain
○ Yes	○ No	Respiratory Disease (Please Circle)_ T.B.,	○ Yes	○ No	Radiation Treatments or X-ray Therapy
		Persistent Cough, Asthma, Sinus Trouble, Hay Fever	○ Yes	○ No	Psychiatric Problems
○ Yes	○ No	Fainting Tendency	○ Yes	○ No	Are you Pregnant
○ Yes	○ No	Frequent Headaches	○ Yes	○ No	Disease or drug that has depressed your immune system
○ Yes	○ No	Abnormal Bleeding or Bruise Easily	○ Yes	○ No	Do you Smoke or use Tobacco
○ Yes	○ No	Thyroid Disease	○ Yes	○ No	Do you use Alcohol
○ Yes	○ No	Hepatitis, Jaundice or Liver Disease	○ Yes	○ No	Do you use Recreational Drugs (Marijuana, Cocaine, etc)

○ Yes ○ No Have you had any difficulty associated with dental treatment?_____

○ Yes ○ No Do you ever had difficulty opening or closing your mouth?_____

○ Yes ○ No Do you have clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?_____

_____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satifaction. I will not hold my surgeon, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient_____ **Date**_____
(or legal guardian if a minor)