

Welcome to _____

Client Information

.....
First Name Last Name
.....
Address
.....
City State Zip
.....
Home Phone Number Work Phone Number
.....
Cell Phone Number Email Address
.....
Social Security Number Date of Birth
.....
Emergency Contact Name Phone Number

Policy Holder/Responsible Party Information

.....
Name of Insured Relationship to Client
.....
Address
.....
City State Zip
.....
Social Security Number Client Insurance ID Number Policy Holder's Date of Birth
.....
Employer Name Insurance Company Group or Policy Number

Dental History

.....
Previous Dentist Name Reason for Leaving
.....
Date of last cleaning Date of last x-rays

Please explain the reason for your visit today:

Dental History

- Y N Are you experiencing any discomfort?
- Y N Do you snore?
- Y N Do you have bleeding gums?

- Y N Do you have bad breath?
- Y N Do you grind your teeth?
- Y N Do you play sports?
- Y N Are you sensitive to hot, cold or sweets?
- Y N Have you ever received Periodontal Therapy?
- Y N Do you take a fluoride supplement?
- Y N Do you use tobacco?
- Y N Do you drink coffee or tea?
- Y N Are you interested in having whiter/brighter teeth?
- Y N Do you have difficulty brushing your teeth?

How would you rate your smile on a scale from 1 to 10, with 10 being the highest? 1 2 3 4 5 6 7 8 9 10

What would you change about your smile if you could? _____

Denture/Partial Clients

- Y N Do you wear a denture or partial?
- How old is your denture or partial? _____
- Y N Does your denture or partial cause irritation?
- Y N Are your dentures loose?

Medical History

.....
 Primary Care Physician Name

Physician's Phone Number

- Y N Are you under a physician's care?
- Y N Have you been hospitalized or had a major operation?
- Y N Have you ever had a serious head or neck injury?
- Y N Women: Are you pregnant, trying to get pregnant or nursing?

If you answered yes to any of the above questions, please explain:

.....
 Are you allergic or do you react adversely to any of the following?

- Y N Aspirin
- Y N Acrylic
- Y N Sulfa drugs
- Y N Penicillin or other antibiotics
- Y N Tetracycline
- Y N Metal
- Y N Barbiturates, sedatives or sleeping pills
- Y N Codeine
- Y N Latex
- Y N Local anesthetics (Novacaine-like medication)
- Y N Milk protein

Other:

Please check any conditions that you currently or previously have had:

- AIDS/HIV Positive
- Excessive thirst
- Parathyroid Disease
- Alzheimer's Disease
- Fainting Spells/Dizziness
- Parkinson's Disease

- | | | |
|--|---|---|
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Pins, Rods, Stints or Shunts |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Diarrhea | |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Pacemaker* | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Sinus Problem |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> None |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pain in Jaw Joints | * Condition may require medication |

List any major illnesses not listed above:

.....

Please check any medications and/or supplements taken in the past 12 months:

- | | |
|---|--|
| <input type="checkbox"/> Antibiotics or sulfa drugs | <input type="checkbox"/> Nitroglycerin |
| <input type="checkbox"/> Tranquilizer | <input type="checkbox"/> Anticoagulants (e.g. Coumadin, blood thinners) |
| <input type="checkbox"/> Aspirin (daily) | <input type="checkbox"/> Contraceptives |
| <input type="checkbox"/> Insulin or diabetes medication | <input type="checkbox"/> Bisphosphonates (used to treat osteoporosis, such as Fosamax, Boniva, Actonel and Zometa) |
| <input type="checkbox"/> Herbal supplements | |
| <input type="checkbox"/> High blood pressure medication | <input type="checkbox"/> Phen-Fen or Redux |
| <input type="checkbox"/> Heart medications | |

List all medications/supplements you are currently taking:

.....

I have answered all questions to the best of my knowledge. I will notify Dr. _____ of any change in my health or medication at each visit.

I authorize Dr. _____ to use the necessary local/topical anesthesia to perform my treatment in a safe, effective manner during this visit and any future visits. I understand that my failure to provide information on previous adverse reactions may cause unforeseen negative reactions. I release Dr. _____ of all liability regarding undisclosed medical history information.

.....
Signature of Client or Guardian

.....
Date

.....
If authorized guardian, relationship to client

.....
Witness Name

.....
Date

.....
Witness Signature

.....
Doctor Signature

.....
Date

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MEDICAL HISTORY UPDATE

Please review your medical history on the previous pages and answer the following questions about any changes to your medical history since your last visit.

	Date / /	Client Initials	Dr. Initials	Date / /	Client Initials	Dr. Initials
Have there been any changes in your medical history since your last visit? If you answered yes, please explain and indicate in the medical history section on the previous page.	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N		
Have you been hospitalized for any reason or had joint replacement surgery since your last visit?	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N		
Have there been any recent changes or additions to your medications? If you answered yes, please explain and indicate in the medications/supplements section on the previous page.	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N		
Are you presently using any herbs, teas, vitamins, or hormone replacements? If yes, please explain and indicate in the medications/supplements section on the previous page.	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N		