Patient Information

Date: _____

Name: _____Home Address: _____

Apt/ PH_____ City: _____ State _____ Zip: _____

Home #: _____ Work #: _____ Mobile #: _____

Employer's Name: _____

Sex: M / F Birth Date: _____ /_____ /_____ SS#: _____

Email: _____

Family Status (circle one): Single Married Dependent

How did you first hear about our office? (circle one):

Existing Patient	A Dental Office	Radio: Trevor Forde	Online Search
Facebook	Walk In	School	Insurance

Other: _____

Whom may we thank for referring you to our practice? _____

Contact Information

What is the best way to communicate with you? Home Phone / Mobile Phone/ Text / Email

In the event of an emergency, whom should we contact? Name _____

Relationship_____ Home #: _____ Mobile #: _____

Medical History

1. Date of last physical exam: _____
2. Have you ever been hospitalized (if yes, explain below)? Yes No

_____

3. Have you been under the care of a medical doctor during the past two years? Yes No

If yes, what for? _____

4. **Women:** Are you pregnant/breast feeding? Yes No
5. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic	Penicillin	Codeine	Other Antibiotic: _____
Latex	Acrylic	Metals	Other:_____

6. Are you taking or have you ever taken any of the following medications (please circle if yes):

Blood Thinners	Aspirin	Heparin	For how long? _____

Coumadin BP medication Diabetic Medication When did you stop? _____

7. Please list other medications you are currently taking:

_____

_____

Have you ever had any of the following?

AIDS	Yes No	Heart Murmur	Yes No	Respiratory Disease	Yes No
Anemia	Yes No	Heart Attack	Yes No	Shortness of Breath	Yes No
Asthma	Yes No	Heart Problems	Yes No	Skin Rash	Yes No
Blood Disease	Yes No	Heart Valve Repl.	Yes No	Sinus Problems	Yes No
Cancer	Yes No	Hepatitis	Yes No	Stroke	Yes No
Chemotherapy	Yes No	High Blood Pressure	Yes No	Thyroid Problems	Yes No
Diabetes	Yes No	Kidney Disease	Yes No	Tuberculosis	Yes No
Dizziness	Yes No	Low Blood Pressure	Yes No	Ulcers	Yes No
Epilepsy	Yes No	Osteoporosis	Yes No	Explain_____	
Fainting	Yes No	Mental Health Problems	Yes No	_____	
Headaches	Yes No	Pacemaker	Yes No	_____	

If any allergies, please indicate: _____

Do you have any of the following dental concerns:

Clicking in jaw joint	Yes No	Sensitivity to: Hot /	Cold / Sweets
Pain in or around your ears	Yes No	Swelling	Bleeding Gums
Difficulty opening or closing	Yes No	Bad Taste	Bad Breath
Difficulty chewing	Yes No	Food Catching	Tooth Pain
History of trauma to jaw or face	Yes No	Clenching	Grinding
Diagnosis of TMJ/TMD	Yes No	Other: _____	

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature: _____ Date: _____

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FOR OFFICE USE ONLY:

UPDATE: MO._____ YR._____ | MO._____ YR._____ | MO._____ YR._____|

MO._____ YR._____ | MO._____ YR._____ | MO._____ YR._____|