WELCOME!

WE WISH YOU ENTER OUR OFFICE AS A PATIENT, SMILE, AND LEAVE AS A FRIEND!

Last_____First_____DOB____/____/_____

If Patient is a minor, name of parent or Legal guardian_____Relationship_____

How did you hear about us? _____

Residence Address:_____

Status:_____ Married ___Single ___ Divorced_____ Widowed Gender___ Male ___Female _____Nonbinary

Cell Phone _____ Home Phone _____ Email_____

SSN_____-_____-_____ Driver License/ID_____

Occupation_____ Employed By_____ Work Address_____

Emergency contact name_____ Phone_____

Name of General Physician_____ Phone_____

Former Dentist_____Phone_____ Reason for changing Dentist_____

Purpose for this appointment_____

Name of Insurance Co (Primary)_____ Group #_____

Insurance person name:_____DOB_____/_____/_____ SSN_____-_____-_____

Name of Insurance Co (Secondary)_____ Group #_____

Insurance person name:_____DOB_____/_____/_____ SSN_____-_____-_____

1.Are You in Good Health? Y N

2. Date of Last Physical Exam?_____/_____/_____ 3. Are you under care of a physician? Y N,

Explain condition being treated?_____ 4. Any Serious Illness or Hospitalization? _____

5. Do You have or had any of the following, Please Circle "Y "for (YES) or "N" for (NO)- Answer all condition

ANEMIA **Y N** GLAUCOMA **Y N** SLEEP APNEA **Y N** ANGINA PECTORIS Y **N** PAIN IN JAW JOINT **Y N**

HERPES **Y N** TONSILLITIS **Y N** SNORING **Y N** MENTAL DISORDER **Y N** HEPATITIS __A,__B,__C **N**

STROKE **Y N** HEMOPHILIA **Y N** HEART MURMUR **Y N** THYROID DISEASE **Y N** TUMORS **Y N**

ULCERS **Y N** COLD SORESS **Y N** LIVER DISEASE **Y N** FAITING SPELLS **Y N** CORTISONE MED Y **N**

DIABETES **Y N** EMPHYSEMA **Y N** BLOOD DISEASE **Y N** RHEUMATIC FEVER **Y N** ALLERGY TO METAL **Y N**

OSTEOPOROSIS **Y N** ARTHRITIS **Y N** TUBERCULOSIS **Y N** EXCESSIVE BLEEDING **Y N** ASTHMA **Y N**

HEART ATTCK **Y N** MITRAL VALVE PROLAPSE **Y N** RADIOTION THERAPY **Y N** CHEMOTHERAPY **Y N** CANCER **Y N**

BRUISE EASILY **Y N** CEREBRAL PALSY **Y N** HIGH BLOOD PRESSURE **Y N** SEIZURE **Y N** MAJOR HEAD INJURY **Y N**

DRUG ADDICTION **Y N** JOINT REPLACEMENT **Y N** HEART FAILURE **Y N** KIDNEY DISEASE **Y N**

SICKLE CELL DISEASE **Y N** IMPLANTS **Y N** SINUS TROUBLE **Y N** HIV/AIDS **Y N** TMJ/JAW CLICKING **Y N**

ARTIFICIAL PROSTHETICS **Y N** DIFICULTY SWALLOWING **Y N** CONGENITAL HEART LESION **Y N**

6. DO YOU HAVE ANY MEDICAL CONDITION NOT LISTED ABOVE? EXPLAIN_____

7. ARE YOU TAKING ANY BLOOD THINNER INCLUDING BABY ASPIRIN? **Y N** MED Name_____

8. DO YOU WEAR CARDIAC PACEMAKER, OR HAVE YOU HAD HEART SURGERY? **Y N**_____

9. DO YOU SMOKE TABACCO PRODUCT? **Y N** HOW MUCH? _____ DO YOU VAPE? **Y N** RECREATIONAL DRUGS? **Y N**

10. HAVE YOU EVER TAKEN? ____FENPHEN ___REDUX____ FOSAMAX_____ ZOMETA____ BONIVA____ ACTONEL

11. (WEMAN) ARE YOU PREGNANT? **Y N** , IF YES, HOW MNAY MONTHS?_____ HIGH RISK PREGNANCY? **Y N**

12. HAVE YOU HAVE ANY UNFAVARBALE REACTION TO ANY DENTAL ANESTHETIC? **Y N**

13. HAVE YOU HAD ANY SERIOUS TROUBLE WITH ANY PREVIOUS DENTAL TREATMENT? **Y N**

14. WOULD YOU DESIRE TO BE SEDATED? **Y N**

DENTAL SLEEP AND AIRWAY HISTORY

15. DO YOU SNORE? **Y N** 16. DO YOU FEEL TIRED DURING THE DAY? **Y N**

MORNING HEADACHE **Y N** DIFICULTY CONCENTRATING **Y N** NEED CAFFEINE THROUGHOUT THE DAY **Y N**

FREQUENT NECK SORENESS **Y N** FORGETFULL NESS **Y N** FREQUENT NIGHT AWAKATING **Y N**

DRY MIUTH **Y N** ACID REFLUX **Y N** BRUXIM/ TETH GRINDING **Y N**

NEED TO URINTE DURING THE NIGHT **Y N** (MEN) E. D **Y N** OBESITY **Y N**

SMILE SELF EVALUATION

1. Are you pleased with the general appearance of your teeth and smile? .Y N If no, please explain:_____

2. Would you like straighter teeth? Y N **3. Are there spaces between your teeth that you dislike? Y N**

4. Are you satisfied with the color of your teeth? Y N **5. Are you satisfied with the shape of your teeth? Y N**

6. Are your gums puffy, red or swollen-looking? Do they bleed easily? Y N **7. EXPERIENCING BAD BREATH? Y N**

8. Do you have old fillings or dental work that you would like to replace? Y N

9. Get food stuck between your teeth? Y N **10. Do you have missing teeth that make chewing difficult? Y N**

10.**What would you like to change about the appearance of your teeth? _____**

LIST OF CURRENT MEDICATIONS:_____

LIST OF ALLERGIES_____

TO THE BEST OF MY KNOWLEDGE ALL OF PROCEEDING ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH OR IF MY MEDICATION CHANGE I WILL INFORM THE DENTIST IN WRITING AT MY NEXT APPOITMENT

SIGN_____ **DATE**_____