In order for us to serve you better, please complete both sides of this form.

Date_____

PATIENT INFORMATION

_____ _____
Last Name First Name Middle Name Preferred Name (How we should address you?)

Sex M/F_____ Married - Single - Child (circle) Birthdate_____ S.S. #_____Driver's Lic. #_____

Patient Address:_____

E-mail_____ Home Ph:_____ Wk Ph:_____ Cell Ph:_____

Fax_____Occupation/Grade/Major_____Employer/School:_____

Work / School Address:_____
City State Zip

How did you hear about our office?_____

Spouse's Name (If applicable) _____Occupation_____Work Phone_____

For all children (under 18):

Father's Name:_____ Occupation_____Work Phone_____

Mother's Name:_____Occupation_____Work Phone_____

Patient lives with (please circle): Father and Mother Father Mother Alternating Other_____

PERSON RESPONSIBLE FOR THIS ACCOUNT (if not the patient)

_____ ❒ Male ❒ Female ❒ Married ❒ Single _____
Last Name First Name Middle Name Birthdate

S.S. #_____Driver's Lic. #_____ Relationship to patient_____ E-mail_____

Address (if different):_____ Home Ph:_____ Cell Ph:_____

Occupation:_____Employer:_____Work Address_____ Wk Ph:_____

DENTAL HISTORY

What is your reason for seeking dental treatment?_____

How long since you have been to a dentist? _____What was done then? _____

Any teeth sensitive to: Heat? ❒ Cold? ❒ Sweets? ❒ Biting Pressure? ❒
Does food catch any place? Where?_____
Do your gums bleed? Yes ❒ No ❒ Do you have bad breath? Yes ❒ No ❒

Do you clench or grind your teeth?	YES	NO	When?_____
Prior orthodontic treatment?	YES	NO	
Were permanent teeth removed for orthodontics?	YES	NO	
Any soreness in your teeth or jaws on waking?	YES	NO	
Do you wear a nighttime appliance?	YES	NO	
Do your jaws click when you chew or open wide?	YES	NO	
Did you now, or have you ever had, pain in your jaw joint or the sides of your face (In and about the ears?)	YES	NO	
Do you like your smile?	NO	YES	

What would you change? ❒ Straighten teeth ❒ Whiten teeth ❒ Close spaces Other:_____

Do you have any fear of having dentistry done? Yes ❒ No ❒ If yes, why?_____

How do you feel about keeping your teeth for the rest of your life? _____

GET ACQUAINTED QUESTIONNAIRE

PLEASE ANSWER EVERY QUESTION

Have you shown an allergy to, become sick from, or been told not to take: (Circle)
Penicillin Erythromycin Other Antibiotics Dental anesthetics Aspirin Codeine Pain Medications Latex Metals Plastic Sedatives Sulfa Other Medications _____

Alcohol Use? No ❒ Yes ❒ # drinks/week____ Tobacco Use? Never ❒ Current ❒ Quit ❒ _____/day for____years
Cafeine Intake? None ❒ Coffee/Tea/Soda ❒ # cups/day_____

Have you been hospitalized or had a serious illness in the last three years? NO YES _____

In your IMMEDIATE family, any history of (circle):
Cancer Diabetes Stroke High Blood Pressure Heart Disease Father Snores Mother Snores Sleep Apnea

Please list ALL medications you are taking (with or without a prescription):_____

_____

(For women) Are you now: Pregnant ❒ Taking birth control pills ❒ Nursing ❒

Do you get to sleep well, stay asleep well, and wake up feeling rested? Yes ❒ No ❒
Has anyone ever said that you snore? No ❒ Yes ❒

Do you now have, or have you ever had any of the following: (please circle YES or NO):

Difficulty Sleeping	YES NO	Need extra pillows	YES NO
Insomnia	YES NO	Sleep Apnea	YES NO
Adenoids removed	YES NO	Tonsils removed	YES NO
Nasal surgery	YES NO	Nasal allergies	YES NO
Tendency for ear infections	YES NO	Chronic fatigue	YES NO
Stroke	YES NO	High blood pressure	YES NO
Heart disorder	YES NO	Heart attack	YES NO
Heart pacemaker	YES NO	Valve replacement	YES NO
Chronic cough	YES NO	High blood pressure	YES NO
Asthma	YES NO	Chronic pain	YES NO
Osteoporosis	YES NO	Immune system disorder	YES NO
Fibromyalgia	YES NO	Anemia	YES NO
Intestinal Disorders	YES NO	Bleeding easily	YES NO
Acid Reflux	YES NO	Arthritis	YES NO
Hepatitis or Liver disease	YES NO	Thyroid disorder	YES NO
Epilepsy	YES NO	Cancer or tumors	YES NO
Headaches	YES NO	Chemo or radiation treatment	YES NO
Backaches	YES NO	Glaucoma	YES NO
Depression	YES NO	Vision impaired	YES NO
Psychiatric care	YES NO	Learning disabilities	YES NO
Kidney problems	YES NO	Hearing impaired	YES NO
Hypoglycemia	YES NO	Prosthetic joint replacement	YES NO
Diabetes	YES NO	Muscular dystrophy	YES NO

Have you ever been told that you should routinely take antibiotics before all dental treatment? YES NO

For Office Use:

❒ NO ALERTS

Do you have other medical problems or diseases NOT listed on this form? YES NO _____

Notify in case of emergency:_____ Address_____Phone_____

Previous Dentist's Name:_____ Address_____Phone_____

Physician's Name: _____ Address_____Phone_____

To the best of my knowledge, I have answered every question completely and accurately. I hereby agree to the use of any procedures, sedative analgesics or anesthetics as are deemed proper and necessary for dental treatment or diagnosis, and I authorize the use of any photographs and video taken for the purpose of dental education. ❒ Photos may also be used for promotional purposes.

Patient or Parent/Guardian_____Date_____