

Date: _____

Patient's Name _____ Birth Date _____ Age _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred Contact: Home / Cell / Work Text Message Appointment Reminders? YES NO

E-mail _____ Referred by _____

Occupation _____ Employed by _____

Dentist _____ Physician _____

Person Financially Responsible _____ Relationship _____

MEDICAL HISTORY

- 1. Are you in good health? Yes No
- 2. Have tonsils and/or adenoids been removed? If yes, at what age? _____ Yes No
- 3. Frequent colds, sore throat, or ear infections? No Yes
- 4. Any allergies or drug sensitivity? If yes, list: _____ No Yes
 - 4a. LATEX? YES / NO
 - 4b. NICKEL? YES / NO
- 5. Any history of major illness? If yes, list: _____ No Yes
- 6. Taking medication now? If yes, list: _____ No Yes
- 7. Under medical care now? If yes, list: _____ No Yes
- 8. Any implanted medical device? (ex: cochlear implant, pacemaker, etc.) If yes, list: _____ No Yes
- 9. Circle any of the following for which you have been diagnosed and/or treated:

Asthma	Diabetes	Endocrine problem	Prolonged bleeding	Heart trouble	AIDS / HIV	Rheumatic fever
Epilepsy	Arthritis	Joint replacement	Nervous disorders	Brain injury	Hepatitis	Tuberculosis
		Osteoporosis	Sensory disorders	Cancer		

DENTAL HISTORY

- 10. Date of last dental exam _____ Is work complete? Yes No
- 11. Have full mouth x-rays ever been taken? If yes, give date _____ Yes No
- 12. Have there been any injuries to the face, mouth, or teeth? No Yes
- 13. Have you ever sucked thumb or fingers? If yes, until what age? _____ No Yes
- 14. Any oral habits, such as lip biting or tongue thrusting? No Yes
- 15. Any finger nail biting? No Yes
- 16. Are you aware of any missing or extra permanent teeth? No Yes
- 17. Has an orthodontist been consulted previously? No Yes
- 18. Would you consider your diet high in sweets? No Yes
- 19. What are you or your dentist most concerned about? _____

Your Signature _____