

PATIENT

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Sex M F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Spouse \_\_\_\_\_

Work Phone \_\_\_\_\_ Marital Status \_\_\_\_\_ E-Mail \_\_\_\_\_

Cell Phone \_\_\_\_\_ Responsible Party \_\_\_\_\_ Relationship \_\_\_\_\_

In Case of Emergency Call \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you to this office? \_\_\_\_\_

Place of Employment \_\_\_\_\_ May we call you at work? YES NO

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Surgical Procedures Last 12 months \_\_\_\_\_

\_\_\_\_\_

Current Medical Treatment \_\_\_\_\_

\_\_\_\_\_

Current Medications (Rx, Vitamins, Supplements) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pre Medicate YES NO (for: Heart Valve, Joints, implants) \_\_\_\_\_

**DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING ?**

- |   |  |
|---|--|
| YES NO HEART ATTACK, CHEST PAIN, ANGINA - NITRO TABS  | YES NO DIABETES, DIET CONTROLLED, INSULIN            |
| YES NO HEART MURMUR, MITRAL VALVE PROLAPSE (MVP)      | YES NO CANCER: Type _____ Date _____                 |
| YES NO RHEUMATIC HEART FEVER, ARTIFICIAL HEART VALVES | YES NO ARTHRITIS                                     |
| YES NO HIGH or LOW BLOOD PRESSURE                     | YES NO KIDNEY DISEASE                                |
| YES NO BYPASS OR ANGIOPLASTY                          | YES NO SMOKER, EMPHYSEMA, C.O.P.D, ASTHMA            |
| YES NO PACEMAKER                                      | YES NO ULCERS, COLITIS, INTESTINAL DISORDERS         |
| YES NO STROKE   | YES NO HERPES or COLD SORES, CANKER SORES            |
| YES NO ALLERGIES: PENICILLIN ERYTHROMYCIN LATEX       | YES NO HIV OR AIDS                                   |
| YES NO Other Allergies _____                          | YES NO LIVER DISEASE, HEPATITIS A OR B OR C          |
| YES NO ARTIFICIAL JOINTS: HIP KNEE OTHER              | YES NO EPILEPSY OR SEIZURES                          |
| YES NO CURRENTLY PREGNANT, NURSING, BIRTH CONTROL     | YES NO BLOOD TRANSFUSIONS, Hospitalized last 2 years |
| YES NO OSTEOPOROSIS, Bisphosphonate medication        |  |

Do you feel well ? YES NO Do you have any other disease, infection or medical condition that we should be aware of ? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Signature or Guardian

Date

**MEDICAL HISTORY**

## Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

These are things that are important to me about my dental health: (Please check one)

1.  My mouth is very comfortable.  
 My mouth is moderately comfortable.  
 My mouth is uncomfortable.
2.  I feel that the appearance of my mouth is very good.  
 I am satisfied with the appearance of my mouth.  
 I am dissatisfied with the appearance of my mouth.
3.  I will do anything to keep my natural teeth.  
 I want to keep my natural teeth, but have certain budgets of time and money I am willing to spend on them.  
 I don't care whether I keep my teeth or not.
4.  I have set goals for my oral health with a previous dentist.  
 I want to set goals concerning my dental health.  
 I am not interested in thinking about the future of my teeth at this time.
5.  I have always completed the care that was recommended for my dental health.  
 I have not done what dentists have recommended for my mouth.  
 I rarely go to the dentist and only do what is necessary to be free of pain and cosmetic embarrassment.
6.  I have put dentistry for myself and my family high on my priority list.  
 I have put dentistry for myself and my family low on my priority list.  
 I have put dentistry for myself and my family on my list but it is hard to find.
7. I think my present state of dental health is:  
 Excellent.  
 Average.  
 Don't have a clue.
8. Should I require some form of treatment, the following best describes my feelings about the types of dental restorations that I would like in my mouth:  
 I want the best restoration possible that will be the most conservative and give the longest life.  
 I want all of the above and I want only tooth colored restorations, even though they may not be as durable and require more care and a greater investment.  
 I want the least expensive restoration that will get me by for now.
9. Please select the single factor that best describes your reason for getting dental care. (Check only one.)  
 Desire to avoid pain.  
 Desire to look my best.  
 Desire to intercept problems early and to avoid preventable expenses in the future.  
 Desire to avoid dentures.  
 Other \_\_\_\_\_
10. Please describe in the order of importance your concerns about your mouth now, as well as any questions that you have always wanted answered about your mouth:

