

Patient Information

DATE _____
NAME _____
MR. _____
MRS. _____
MS. _____
(LAST) (FIRST) (MIDDLE) (HOME PH. #)

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

EMPLOYMENT _____
EMPLOYER _____ BUSINESS ADDRESS _____ BUSINESS PHONE # _____

OCCUPATION: _____

DATE OF BIRTH _____ SS # _____ D. L. # _____

SPOUSE'S NAME _____ BIRTHDATE _____ SPOUSE'S OCCUPATION _____

PERSON RESPONSIBLE FOR ACCOUNT _____ ADDRESS _____

DENTAL INSURANCE: Y N NAME OF INSURANCE CO. _____

IF YES, PLEASE BRING INS. CARD TO RECEPTIONIST WITH THIS FORM _____

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE PREVIOUSLY Y N NAME _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

WHY DID YOU CHOOSE DR. MARTIN AS YOUR DENTIST? _____

On scale of 1-10 (10 being highest) how do you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

MEDICAL HEALTH

General Health (please check): EXCELLENT GOOD FAIR POOR Last complete physical _____

In case of emergency notify: Name _____ Phone # _____

Are you taking any medication now? Yes No For what purpose? _____

Do you have now or have you ever had:					
Heart disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Jaundice	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rheumatic fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>	A Positive (HIV/AIDS) test	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Abnormal blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ulcers	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pacemaker	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Blood disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Epilepsy or seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sinus trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thyroid problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bleeding problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other Respiratory problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Have you ever had a blood transfusion?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Radiation Treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Kidney trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chemotherapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Drug addiction	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Allergies or hives	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Psychiatric treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Other Medical problems not listed above? _____

Are you allergic to Penicillin Codeine Local anesthetics Other medications

Are you subject to prolonged bleeding Yes No Are you subject to fainting spells? Yes No

MEDICAL INFORMATION

(Continued)

- 1. Female: Are you pregnant? _____
- 2. Have you ever been told you needed to take antibiotics before dental appointments? _____
- 3. Are you presently taking any other medication? _____
If yes, what? _____
- 4. Are you presently under a physician's care? _____
If yes, for what? _____
Physician's Name: _____
Phone Number: _____

DENTAL INFORMATION

(Fill in or Check)

- | | YES | NO |
|--|-------|-------|
| 1. When was your last dental visit? _____ | _____ | _____ |
| 2. When was your last dental cleaning? _____ | _____ | _____ |
| 3. How often do you brush? _____ | _____ | _____ |
| 4. How often do you floss? _____ | _____ | _____ |
| 5. When were your last dental x-rays taken? _____ | _____ | _____ |
| 6. Have you ever seen a dental specialist? _____
If yes, for what? _____ | _____ | _____ |
| 7. Are you apprehensive about dentistry? _____
If so, please explain? _____

_____ | _____ | _____ |
| 8. Do your gums bleed? _____ | _____ | _____ |
| 9. Are you aware of clenching or grinding your teeth during the day or night? _____ | _____ | _____ |
| 10. Do you have chronic headaches? _____ | _____ | _____ |
| 11. Do you wake up with headaches or jaw pain? _____ | _____ | _____ |
| 12. Do you or have you had a pain in your ears? _____ | _____ | _____ |
| 13. Does your jaw joint click or pop? _____ | _____ | _____ |
| 14. Have you ever been unable to open your mouth widely or move your jaw? _____ | _____ | _____ |

Are you happy with the appearance of your teeth? _____

Do you have any additional comments or special expectations of our office:

I verify the information given is true to the best of my knowledge: _____

Signature