Custom Dental

Last Name	First	Middle Initial	Home#	Work#	Cell#

Date of Birth	SSN#	Marital Status	Spouse's Name

Home Address	City	State	Zip	Referred By	Email

Employer	Address	City/State	Zip	Emergency Contact Name and Phone number (not living with you)

May we text you? Yes / No May we email you? Yes / No

Are you in good health? Yes / No
Are you now under a physician's care? Yes / No
Have you ever had any serious illnesses? Yes / No
--If yes, please describe? _____

_____

HOW DO YOU FEEL ABOUT SAVING YOUR TEETH?
Not Important Very Important
0 1 2 3 4 5 6 7 8 9 10

HOW WOULD YOU EVALUATE YOUR SMILE?
Ugly Beautiful
0 1 2 3 4 5 6 7 8 9 10

DO YOU CURRENTLY OR HAVE YOU EVER HAD (please circle)

Allergies-Seasonal Yes / No
Anemia Yes / No
Arthritis Yes / No
Artificial Joints Yes / No
--If yes, how long ago? _____
Asthma Yes / No
Blood Disease Yes / No
Cancer Yes / No
Diabetes Yes / No
--If yes, what type? _____
Dizziness Yes / No
Epilepsy Yes / No
Excessive Bleeding Yes / No
Fainting Yes / No
Glaucoma Yes / No
Head Injury Yes / No
--If yes, how long ago? _____
Heart Disease Yes / No
Heart Murmur Yes / No
Hepatitis Yes / No
--If yes, what type? _____
High Blood Pressure Yes / No
HIV/AIDS Yes / No
Jaundice Yes / No
Kidney Disease Yes / No
Liver Disease Yes / No
Nervous Disorders Yes / No
Pacemaker Yes / No
Radiation Treatment Yes / No
Respiratory Issues Yes / No
Sinus Issues Yes / No
Stomach Issues Yes / No
Stroke Yes / No
Tuberculosis Yes / No
Tumors Yes / No
Ulcers Yes / No

Any other medical issues not listed? Yes / No
--If yes, please explain:_____

_____

_____

During the past 12 months, have you taken any of the following? :
Antibiotics Yes / No
Blood Thinners, Aspirin Yes / No
High Blood Pressure Medication Yes / No
Tranquilizers Yes / No
Insulin or other Diabetic Medication Yes / No
Heart Medication of any kind Yes / No
Please list any medications taken, including prescriptions, over the counter medications, herbal, vitamins, or minerals: _____

_____

_____

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:
Local Anesthesia Yes / No
Penicillin or other Antibiotics Yes / No
Sedatives, Barbiturates Yes / No
Aspirin or Ibuprofen Yes / No
Codeine, Demerol or other narcotics Yes / No
Latex or Rubber Products Yes / No
Reaction to Metals Yes / No
Sulfa Drugs Yes / No
Other allergies or adverse reactions:_____

_____

Do You Smoke or chew tobacco? Yes / No
Do you snore, gasp or choke while sleeping? Yes / No
--If yes, please list: _____
Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? Yes / No
--If yes, please explain: _____
Have you had any serious problems associated with any previous dental treatment? Yes / No
--If yes, please explain: _____
Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes / No
--If yes, please list: _____

_____

Women Only: Are you pregnant or is there any chance you might be pregnant? Yes / No
--If yes, when is your due date? _____
-- If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives.

Patient Signature:_____Date:_____