Adult Dental and Medical History (New Patients)

Today's Date: _____

Patient's Name: _____ I Prefer to be called: _____

Date of Birth: _____ ☐ Male ☐ Female SSN: _____

Address: _____

CITY STATE ZIP

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ ☐ Single ☐ Married

Employer Name: _____ Employer Phone #: _____

Emergency Contact Name: _____

Name Phone Number

How did you hear about us? _____

Insurance Information

Primary Insurance: _____ Phone #: _____

Insured Name: _____ Employer: _____

Insured DOB: _____ Relation to patient: _____

ID #: _____ Group #: _____

Secondary Insurance: _____ Phone #: _____

Insured Name: _____ Employer: _____

Insured DOB: _____ Relation to patient: _____

ID #: _____ Group #: _____

Dental History:

Former Dentist: _____

When did you last visit the dentist: _____ When was your last cleaning: _____

Why did you leave that office? _____

Are you aware of any dental problems? ☐ Yes ☐ No Please Explain: _____

Have you ever been treated for gum disease? ☐ Yes ☐ No What was done? _____

Are your teeth sensitive to: ☐ Nothing ☐ Sweet ☐ Cold ☐ Heat ☐ Pressure

Please rate the appearance of your smile: Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Would you like a whiter smile?..... ☐ Yes ☐ No

Would you like straighter teeth?..... ☐ Yes ☐ No

Have you had your teeth straightened/worn braces?..... ☐ Yes ☐ No

Are you concerned with bad breath?..... ☐ Yes ☐ No

Are you concerned about snoring or sleep apnea?..... ☐ Yes ☐ No

Are you concerned with grinding or clenching your teeth (bruxism)?..... ☐ Yes ☐ No

Are you aware of possible TMJ problems (jaw makes noise, locks up, or creates pain)?..... ☐ Yes ☐ No

(Please continue on back)

Medical History:

Are you under the care of a physician? ☐ Yes ☐ No If yes, what reason: _____

Are you currently taking any medications, supplements, herbals? ☐ Yes ☐ No

If yes, please list: _____

Ladies, is there a chance you are pregnant? ☐ Yes ☐ No If yes, anticipated due date: _____

Are you taking birth controls? ☐ Yes ☐ No

Are you allergic/sensitive to anything: ☐ Yes ☐ No

If yes, please explain: _____

Do you smoke, chew tobacco, or use E-cigarettes? ☐ Yes ☐ No

Do you take pre-medication for anything? ☐ Yes ☐ No If yes, what for? _____

Have you had any serious illness, hospitalization or accident? ☐ Yes ☐ No

If yes, please explain: _____

Do you have or have you ever had:

Abnormal blood pressure	Yes	No	Anemia.	Yes	No	Arthiritis	Yes	No
Artificial heart valve/stent/graft	Yes	No	Fainting spells	Yes	No	Kidney trouble	Yes	No
Artificial joint replacement	Yes	No	Glaucoma	Yes	No	Oral herpetic lesions	Yes	No
Asthma	Yes	No	Hearing impaired.	Yes	No	Osteoporosis	Yes	No
Cancer/Leukemia	Yes	No	Heart murmur	Yes	No	Psychiatric care.	Yes	No
Chemical dependency	Yes	No	Heart pacemaker	Yes	No	Rheumatic fever	Yes	No
Chemotherapy/radiation	Yes	No	Heart surgery	Yes	No	Sexually transmitted disease	Yes	No
Congenital heart defects	Yes	No	Heart trouble	Yes	No	Sinus trouble	Yes	No
Corticosteroid treatment	Yes	No	Hepatitis (Type……)	Yes	No	Stroke	Yes	No
Diabetes (Type …….)	Yes	No	HIV positive	Yes	No	Thyroid problem	Yes	No
Epilepsy/seizure	Yes	No	Jaundice	Yes	No	Tuberculosis/lung disease	Yes	No
Excessive bleeding	Yes	No				Ulcers/GERD	Yes	No

Is there anything that would be valuable for your dentist to know to best care for you?

Please explain: _____

☐ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

☐ I authorize the release of any information concerning my (or my child's) healthcare, advice and treatment to another dentist.

☐ I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications, and/or drugs (including recreational and over the counter) that I am taking or have taken in the last month.

Patient Signature: _____ Date: _____

(Parent/Guardian)

Dentist Signature: _____ Date: _____

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