

**PLEASE COMPLETE THE FOLLOWING**  
(PLEASE PRINT OR TYPE)

**GENERAL INFORMATION**

Dr.  
 Mr.  
 Mrs.  
 Miss  
 Ms.

Date \_\_\_\_\_  
Birthdate \_\_\_\_\_  
Last, First, Middle \_\_\_\_\_

Residence Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Number, Street, City, State, Zip Code Include Area Code

If less than one year, your previous address \_\_\_\_\_  
Number, Street, City, State, Zip Code

Marital Status \_\_\_\_\_ Social Security No. \_\_\_\_\_ Driver's license No. \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address of Employer \_\_\_\_\_ Telephone \_\_\_\_\_  
Number, Street, City, State, Zip Code Include Area Code

Name of Spouse \_\_\_\_\_ Spouse's Social Security No. \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address of Employer \_\_\_\_\_ Telephone \_\_\_\_\_  
Number, Street, City, State, Zip Code Include Area Code

If patient is a minor, who is legally responsible? \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Number, Street, City, State, Zip Code Include Area Code

By whom were you referred? \_\_\_\_\_ When? \_\_\_\_\_

**INSURANCE INFORMATION**

*If you have any type of dental insurance, please complete the following. If not, turn the page.*

Name of Insurance Carrier \_\_\_\_\_

Name of Group Dental Plan \_\_\_\_\_ Group No. \_\_\_\_\_

Employee's Name \_\_\_\_\_ Employee's Social Security No. \_\_\_\_\_

Patient \_\_\_\_\_ Relationship to employee \_\_\_\_\_ Employee's Birthdate \_\_\_\_\_

Employer \_\_\_\_\_

Address of Employer \_\_\_\_\_ Telephone \_\_\_\_\_  
Number, Street, City, State, Zip Code Include Area Code

Union Local Name \_\_\_\_\_ Union Local No. \_\_\_\_\_

Address of Union \_\_\_\_\_ Telephone \_\_\_\_\_  
Number, Street, City, State, Zip Code Include Area Code

Has the patient had previous dental care under this plan? \_\_\_ If yes, when? \_\_\_\_\_

Is the patient covered by another plan? \_\_\_\_\_ If yes, Name of the Plan \_\_\_\_\_

Employer \_\_\_\_\_

Address of Employer \_\_\_\_\_ Telephone \_\_\_\_\_  
Number, Street, City, State, Zip Code Include Area Code

**Please be sure to obtain a copy of the Office Policy regarding Insurance Programs**

**PLEASE TURN THE PAGE**

# MEDICAL HISTORY

Family Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Number, Street, City, State, Zip Code Include Area Code

Additional Physician \_\_\_\_\_ Speciality \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Number, Street, City, State, Zip Code Include Area Code

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Date of last complete medical examination \_\_\_\_\_

Please encircle **YES** **NO** If YES, please fill in details

YES NO Do you have a current medical problem? What? \_\_\_\_\_

YES NO Do you have heart trouble? What kind? \_\_\_\_\_

YES NO Have you ever been told you have a heart murmur? \_\_\_\_\_

YES NO Have you had rheumatic fever? When? \_\_\_\_\_

YES NO Do you have high or low blood pressure? Is it controlled? \_\_\_\_\_

YES NO Have you had pains in the chest or shortness of breath? \_\_\_\_\_

YES NO Do your ankles ever swell? \_\_\_\_\_

YES NO Has your physician ever told you that you are anemic? \_\_\_\_\_

YES NO Have you ever had a stroke? When? \_\_\_\_\_

YES NO Have you ever had diabetes? How is it controlled? \_\_\_\_\_

YES NO Are you subject to fainting or dizziness? When? \_\_\_\_\_

YES NO Do you have headaches? How often? \_\_\_\_\_

YES NO Do you have problems with insomnia? How Often? \_\_\_\_\_

YES NO Do you have any nervous disorder? How is it controlled? \_\_\_\_\_

YES NO Do you take tranquilizers or sedatives? How Often? \_\_\_\_\_

YES NO Do you take aspirin? How Often? \_\_\_\_\_

YES NO Are you allergic to Latex? \_\_\_\_\_

YES NO Are you allergic to any medication? What? \_\_\_\_\_

YES NO Have you ever been advised not to take any medication? What? \_\_\_\_\_

YES NO Do you have asthma or hay fever? How is it controlled? \_\_\_\_\_

YES NO Have you ever had tuberculosis? When? \_\_\_\_\_

YES NO Have you been informed you have HIV/ARC/AIDS? \_\_\_\_\_

YES NO Have you ever had infectious hepatitis? When? \_\_\_\_\_

YES NO Do you have arthritis? How is it controlled? \_\_\_\_\_

YES NO Have you ever had a tumor or cancer? How was it treated? \_\_\_\_\_

YES NO Have you ever had any major operations? What kind? \_\_\_\_\_

YES NO Have ever been involved in a serious accident? What? \_\_\_\_\_

YES NO Are you taking any medication? Please list:

Taking _____	For _____	Taking _____	For _____
Taking _____	For _____	Taking _____	For _____
Taking _____	For _____	Taking _____	For _____

YES NO Have gained or lost weight in the last year? How much? \_\_\_\_\_

YES NO Do you become fatigued easily? At what time of day? \_\_\_\_\_

YES NO Do you routinely eat breakfast? What? \_\_\_\_\_

YES NO Do you take more than one alcoholic drink per day? How many? \_\_\_\_\_

YES NO Do you use tobacco? How Much? \_\_\_\_\_

YES NO Is your diet medically supervised? For what purpose? \_\_\_\_\_

## FOR WOMEN

YES NO Are you pregnant? Expected delivery date? \_\_\_\_\_

YES NO Do you have any history of previous miscarriages? \_\_\_\_\_

YES NO Have you reached menopause? If so, are you taking supportive medication? \_\_\_\_\_

# DENTAL HISTORY

Previous Dentist \_\_\_\_\_ Period of Treatment \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Number, Street, City, State, Zip Code Include Area Code

Other Dentist \_\_\_\_\_ Period of Treatment \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Number, Street, City, State, Zip Code Include Area Code

Last dental visit? \_\_\_\_\_ Last full-mouth x-ray? \_\_\_\_\_ Last complete dental exam \_\_\_\_\_

What is your immediate dental concern? \_\_\_\_\_

Please encircle **YES** **NO** If YES, please fill in details

YES NO Are you presently in any dental pain? \_\_\_\_\_

YES NO Have you ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_  
What? \_\_\_\_\_

YES NO Have you lost any teeth? From what cause? \_\_\_\_\_

YES NO Have you ever had orthodontic treatment? When? \_\_\_\_\_

YES NO Do you have any growths or swellings in your mouth? \_\_\_\_\_

YES NO Do you have any difficulty in swallowing? \_\_\_\_\_

YES NO Do your gums bleed when brushing your mouth? \_\_\_\_\_

YES NO Do you avoid brushing any part of your mouth? Why? \_\_\_\_\_

YES NO Have you ever been told you have pyorrhea? When? \_\_\_\_\_

YES NO Is any part of your mouth sensitive to temperature, pressure, food or drink? What? \_\_\_\_\_

YES NO Do you have a burning sensation in your mouth? \_\_\_\_\_

YES NO Have you ever had a bad reaction to a dental anesthetic? When? \_\_\_\_\_

YES NO Does food catch between your teeth? \_\_\_\_\_

YES NO Do you have pain or soreness around your eyes, ears or other parts of your face? \_\_\_\_\_  
When? \_\_\_\_\_

YES NO Are you aware of stiff neck muscles? How often? \_\_\_\_\_

YES NO Do you ever awaken with awareness of your teeth or jaws? How often? \_\_\_\_\_

YES NO Are you aware of clenching your teeth during daytime hours? How often? \_\_\_\_\_

YES NO Have you ever been told you grind your teeth during sleep? How often? \_\_\_\_\_

YES NO Are you aware of your jaw clicking or popping while eating or yawning? How Often? \_\_\_\_\_

YES NO Do you have difficulty in opening your mouth widely? \_\_\_\_\_

YES NO Do you have "tension" headaches/ How often? \_\_\_\_\_

YES NO Do you have an unpleasant taste or odor in your mouth? \_\_\_\_\_

YES NO Are you dissatisfied with your teeth and their appearance? \_\_\_\_\_

YES NO Do you feel you will eventually wear full artificial dentures? \_\_\_\_\_

YES NO Do any members of your family including your parents wear dentures? \_\_\_\_\_

YES NO Do you think your dental disease is active? \_\_\_\_\_

YES NO Do you want to learn to control your dental disease and retain your teeth? \_\_\_\_\_

YES NO Are you deeply concerned about the finances required to return your mouth to excellent dental health? \_\_\_\_\_

YES NO Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? \_\_\_\_\_

# SUPPLEMENTAL DENTURE HISTORY

If you wear a partial or complete artificial denture, please complete the following:

For what reason were your teeth lost? \_\_\_\_\_

When did you receive your first partial or complete denture? \_\_\_\_\_

Approximate date of extractions: \_\_\_\_\_

Was your first complete denture placed the same day the teeth were extracted? \_\_\_\_\_

How many complete or partial dentures have you had? Upper? \_\_\_\_\_ Lower? \_\_\_\_\_

How long have you worn your present denture? \_\_\_\_\_

Has it been relined? \_\_\_\_\_

Your last denture was constructed by: \_\_\_\_\_

What is your present denture problem? \_\_\_\_\_

Are you satisfied with the appearance of your dentures? \_\_\_\_\_

Are you satisfied with the comfort of your dentures? \_\_\_\_\_

Are you satisfied with the chewing ability? \_\_\_\_\_

Do you wear your dentures 24 hours a day? \_\_\_\_\_ If not, why not? \_\_\_\_\_

Do you bite your tongue or cheek with your dentures? \_\_\_\_\_

Do your dentures click during speech? \_\_\_\_\_

Is your speech influenced by your dentures? \_\_\_\_\_ How? \_\_\_\_\_

What do you expect of your new denture? \_\_\_\_\_

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and his/her Staff, and assume financial responsibility for payment, including all terms and conditions set forth in the Office Policy regarding financial arrangements, of which I hereby acknowledge receipt. This office charges a late fee of \$10 or 10% of the late balance, in our sole discretion, for any payments not made within 7 days of the notice of delinquency. By authorizing treatment to be rendered, you agree that you will be responsible for this late fee in addition to the balance you owe for the provided services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

***Please be sure to obtain a copy of the Office Policy regarding financial arrangements.***