

## PATIENT HEALTH & DENTAL HISTORY

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
 Address \_\_\_\_\_ City & State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Business \_\_\_\_\_ Emergency \_\_\_\_\_  
 Mobile Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
 Person to Notify in Case of Emergency \_\_\_\_\_ Relationship \_\_\_\_\_  
 Name & Address of Closest Living Relative Not Living with You \_\_\_\_\_  
 \_\_\_\_\_  
 Place of Employment \_\_\_\_\_  
 Driver's License # \_\_\_\_\_ State Issued \_\_\_\_\_  
 Person Responsible for Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_  
 Whom May We Thank for Referring You to Our Office \_\_\_\_\_

### PLEASE CIRCLE THE CORRECT RESPONSE AND ANSWER ALL QUESTIONS

Are you taking any medication now, including regular dosages of aspirin?      Yes      No  
 If so, please list name and dosage \_\_\_\_\_  
 (Use page 2 if needed to list all medications)  
 Are you aware of having an allergic reaction to any medication or substance?      Yes      No  
 If so, please list \_\_\_\_\_  
 Have you been under the care of a medical doctor during the past two years?      Yes      No  
 If so, for what? \_\_\_\_\_  
 Have you seen an ENT (ear, nose and throat doctor)?      Yes      No      Name \_\_\_\_\_  
 Have you seen a chiropractor?      Yes      No      Name \_\_\_\_\_  
 Have you seen a neurologist?      Yes      No      Name \_\_\_\_\_

**Indicate which of the following you have or have had in the past. Circle "yes" or "no" to each.**

Heart Concerns	Yes	No	Hepatitis	Yes	No
Congenital Heart Disease	Yes	No	AIDS/HIV	Yes	No
Heart Murmur	Yes	No	Drug/Alcohol Abuse	Yes	No
High Blood Pressure	Yes	No	Sickle Cell Disease	Yes	No
Mitral Valve Prolapse	Yes	No	Neurological Disorders	Yes	No
Artificial Heart Valve	Yes	No	Psychiatric/Psychological	Yes	No
Pacemaker	Yes	No	Posture Problems	Yes	No



Your Name \_\_\_\_\_

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Here are some things we are going to be talking about at your first visit. These are issues you have probably never thought of. Please check what best expresses how you feel about the following questions.

- Are you having any areas of concern? \_\_\_\_\_
  
- Tell us, in your opinion, what you think the present state of the health of your mouth is? \_\_\_\_\_
  
- What do you already know about our office and what are your expectations?  
\_\_\_\_\_
  
- How healthy do you want us to get your mouth?  
Don't really care                      Average                      The best it can be
  
- Should you need treatment, at what point should we address it?  
When my tooth hurts or breaks  
When something is worsening  
When something isn't ideal
  
- What quality of dentistry do you want us to recommend?  
Just patch it                      Average                      Ideal/the best
  
- We have the ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you?  
As a **general** dentist              As a **cosmetic** dentist              As a **functional** dentist
  
- How do you feel about the appearance of your face and smile? \_\_\_\_\_  
\_\_\_\_\_
  
- What would it take for you to trust us to be your dentist? \_\_\_\_\_  
\_\_\_\_\_
  
- Tell us about your **good** dental experience... \_\_\_\_\_  
And the **bad** ones... \_\_\_\_\_
  
- Has fear ever been an issue for you in a dental office? \_\_\_\_\_
  
- What caused you to leave your last dental office? \_\_\_\_\_

- Has time ever been a factor in getting your dental work done?\_\_\_\_\_
- Has the cost of dental treatment been a concern for you?\_\_\_\_\_
- What can we do to help you with this?\_\_\_\_\_

Is there any additional information you would like us to know?\_\_\_\_\_

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