NAME_____ BEST PHONE #S_____
ADDRESS_____ _____
CITY_____STATE_____ EMAIL_____
ZIP_____ SSN_____
EMPLOYER_____ DOB_____
PERSON TO CONTACT IN CASE OF ER_____ ER PHONE #_____
HOW DID YOU HEAR ABOUT US?_____

PHYSICIAN_____PHONE#_____
ARE YOU BEING TREATED FOR ANY MEDICAL CONDITION?_____IF "YES" WHAT?_____
_____
_____
HAVE YOU BEEN TOLD THAT YOU SNORE?_____
DO YOU USE OR HAVE YOU USED A CPAP?_____
WHAT MEDICATIONS ARE YOU TAKING?_____
_____
WHAT MEDICATIONS ARE YOU ALLERGIC TO?_____

DO YOU OR HAVE YOU EVER HAD? PLEASE CHECK EVERY BOX YES OR NO

	Y	N		Y	N		Y	N
HEART DISEASE			ARTIFICIAL JOINT			THYROID CONDITION		
HIGH BLOOD PRESSURE			LUNG CONDITION			AUTOIMMUNE DISEASE		
HEART MURMUR			TUBERCULOSIS			TAKEN PHEN-FEN		
HEART ATTACK/ANGINA			ULCER			BLOOD TRANSFUSION		
HEART SURGERY			GASTRIC REFLUX			DRUG ADDICTION		
PACEMAKER			CANCER			FAINT EASILY		
STROKE			ANY TUMOR			BRUISE EASILY		
DIABETES			RADIATION TREATMENT			WEIGHT GAIN		
HIV			CHEMOTHERAPY			WEIGHT LOSS		
LIVER DISEASE			LYMPHADENOPATHY			ANYTHING ELSE		
HEPATITIS B, C			LEUKEMIA					
KIDNEY DISEASE			ARTHRITIS			**USE THE FOLLOWING:**		
LATEX ALLERGY			OSTEOPOROSIS			TOBACCO PRODUCTS		
ALLERGIES			OSTEOPOROSIS TREATMENT			ALCOHOL		
HAY FEVER			EPILEPSY/ SEIZURES			COCAINE		
ASTHMA			GLAUCOMA			OTHER DRUGS		

WOMEN: ARE YOU PREGNANT?_____TAKING BCP?_____

REASON FOR TODAY'S VISIT_____
WHEN WAS YOUR LAST DENTAL VISIT?_____WHAT WAS DONE?_____
WHAT DO YOU DO TO CLEAN YOUR TEETH/MOUTH?_____
ANY SENSITIVITY TO HOT/COLD/BITING?_____WHERE?_____
ANY BLEEDING GUMS?_____WHERE?_____
ANY LOOSE TEETH?_____WHERE?_____
HOW OFTEN IS YOUR MOUTH DRY?_____LIPS DRY?_____
HOW OFTEN DO YOU CLENCH OR GRIND YOUR TEETH?_____
HOW OFTEN DO YOU HAVE JAW MUSCLE SORENESS?_____HEADACHES?_____
DO YOU OR HAVE YOU WORN A NIGHTGUARD?_____
HOW LONG DO YOU WANT TO KEEP YOUR TEETH?_____
ANYTHING YOU WOULD LIKE TO CHANGE ABOUT YOUR TEETH OR SMILE?_____
_____

I CERTIFY THAT THE INFORMATION PROVIDED IS COMPLETE AND ACCURATE.

X_____DATE_____