DATE:	GENERAL HEALTH INFORMATION	CHART #	
PATIENT NAME:LAST	FIRST	BIRTH DATE:	AGE:
Reason for Visit / Main Concern? Chec	k-Up ☐ Cleaning ☐ Toothache ☐	Other	
DENTAL HISTORY		SMILE SELF ASSESSMEN	
O When did you last visit a dentist?			YES D NO D
O When were dental x-rays taken?		onscious when smiling or	
O When was your last dental cleaning?	showing your t		TESU NOU
O Have you had gum or periodontal therapy?	3,11	with the color of your teeth?	YES□ NO□
O Do your gums bleed easily?	YES NO Are your gume		YES NO
O Do you feel you have bad breath?	YESU NOU		
O Do you have difficulty flossing?	YES NO DO Do you have o	chipped teeth, crooked teeth,	YES□ NO□
O Are your teeth sensitive to hot or cold?			
 Do you grind your teeth or have symptoms near your ears such as clicking, popping, pain or locking open? 	YES NO Cosmetic Den improve your s	ested in learning how atistry or Orthodontics can	YES D NO D
O Are you in pain or discomfort?	YES NO	Sittle:	
If yes, describe the location of the pain or di	iscomfort and when did this begin?		
O Have you ever been previously dissatisfied	with dental treatment? YES NO		
If yes, please describe:	MEDICAL HIGTORY		
O Are you under a Doctor's care at this time?	MEDICAL HISTORY	Dr Name:	
The you dilider a Doctor's care at this time:	TEG a NO a II yes, please specily.	Dr. Phone: ()	
Are you allergic to penicillin, codeine, local aAre you taking any medications at this time,		s or medicine?	
○ (Women) Are you pregnant now? YES □ N	IO □ If yes, how many months?	Are you nursing? VES	S D NO D
Are there any other health problems of which			
O Name of previous Dentist?	Reason for leaving previous I	Dontiet?	
O Can we contact your previous Dentist to ge			
O Do you have, or have you had, any of the fo		32 110 2	
	Octor Comments Please check "YES"	or "NO" Do	ctor Comments
	HIGH BLOOD PRESS		
	JAUNDICE		
	JOINT REPLACEMEN		
	KIDNEY DISEASE		
ARTHRITIS YES NO	LATEX ALLERGY	YES 🔲 NO 🖵	
ASTHMA YES NO	LIVER PROBLEMS	YES 🔲 NO 🖫	
BISPHOSPHONATE THERAPY YES NO	LOW BLOOD PRESS	SURE YES 🗆 NO 🗎	
BLEEDING PROBLEMS YES NO	LUNG DISEASE	YES 🗆 NO 🖵	
	PACEMAKER		
	PHEN-FEN/REDUX		
	PSYCHIATRIC CARE	YES NO D	
	RHEUMATIC FEVER		
1-0	SINUS TROUBLE		
	SLEEP APNEA		
	TOBACCO STROKE		
	STROKE THYROID PROBLEM	IS YES INO I	
	THTAGB FROBLEM		
	TUBERCULOSIS		
	VENEREAL DISEASE		
To the best of my knowledge, I have answered every ques certify that I consent to taking x-rays and an oral examinati	tion completely and accurately. I will inform my denti ion.	ist of any change in my health and/or	medication. I further
Patient's signature(Parent if Patient is a Minor)		Date	
MEDICAL UPDATE:			
	Doctor Signature		
Patient's signature			

PATIENT INFORMATION

INSURANCE / DENTAL PLAN Primary: Insurance PPO HMO (Circle one) Plan Name
Primary: Insurance PPO HMO (Circle one) Plan Name
Plan Name
Address
City, Zip
City, Zip
Insurance / Plan Phone # Employer Union/Local Group # Plan# Insured's Name Insured's Soc. Sec. # Birthdate
Employer Group # Plan# Insured's Soc. Sec. # Birthdate
Union/Local Group # Plan# Insured's Name Insured's Soc. Sec. # Birthdate
Insured's Name Birthdate
Insured's Soc. Sec. # Birthdate
NOUDANGE (DENTAL DI AN
NSURANCE / DENTAL PLAN
Secondary: Insurance PPO HMO (Circle one)
•
Plan Name
Address
City, Zip
nsurance / Plan Phone #
Employer
Jnion/Local Group # Plan#
nsured's Name
nsured's Soc. Sec. # Birthdate
INSURANCE / MEDICAL PLAN
INSURANCE / MEDICAL PLAN
Primary: Insurance PPO HMO (Circle one)
OL NI
Plan Name
Plan NameAddress
Address
AddressCity, State, Zip
Address City, State, Zip Insurance / Plan Phone # Employer
Address City, State, Zip Insurance / Plan Phone # Employer
Address City, State, Zip Insurance / Plan Phone #

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Date

Signature of Responsible Party or Patient (Parent if Patient is a Minor)