

Patient Name: \_\_\_\_\_ (Last) (First) (Nickname) DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Are you a full time student? Yes No School: \_\_\_\_\_

Reason for this visit: \_\_\_\_\_

How many times do you brush your teeth each day? \_\_\_\_\_ Do you use dental floss each day? Yes No Sometimes

Do your gums bleed? Yes No Have you had your wisdom teeth removed? Yes No

Do you now have pain in your jaw joint? Yes No Do you grind or clench your teeth? Yes No  
If yes, explain: \_\_\_\_\_

Do you now or have you ever smoked tobacco or used chewing tobacco? Yes A few times Used to but not now Never

Have you ever had any complications from or problems with dental treatment? Yes No  
If yes, explain: \_\_\_\_\_

What is your level of anxiety or stress with dental treatment? Low Moderate High

Have you ever had any of the following? Please check those that apply:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Nervous disorders	<input type="checkbox"/> Tumors
<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> Mental disorders	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Allergies: _____	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Venereal disease/ STD
_____	<input type="checkbox"/> Hay fever	Due date: _____	
<input type="checkbox"/> Abnormal bleeding	<input type="checkbox"/> Head injuries	<input type="checkbox"/> Radiation treatment	OTHER:
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart disease/problems	<input type="checkbox"/> Respiratory problems [	<input type="checkbox"/> _____
<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> _____
<input type="checkbox"/> Blood disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Stomach problems	<input type="checkbox"/> _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> _____
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> _____

If you answered yes to any of the above, please explain: \_\_\_\_\_

Have you been admitted to a hospital or had surgical treatment for any condition? Yes No  
If yes, please explain: \_\_\_\_\_

Are you now under the care of a physician for a specific problem? Yes No  
If yes, please explain: \_\_\_\_\_

Name of physician: \_\_\_\_\_ Date of last routine physical exam: \_\_\_\_\_

Do you have any health or dental problems that need further clarification? Yes No  
If yes, please explain: \_\_\_\_\_

Are you now taking any medications either over-the-counter or prescribed? Yes No  
If yes, please list medication and reason: \_\_\_\_\_

Are you allergic to any medications? Yes No If yes, please list: \_\_\_\_\_

Please list any sports you participate in: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

Signature of parent, guardian, or patient aged 18 years or older \_\_\_\_\_ Date: \_\_\_\_\_