NAME_____

CELL NUMBER_____HOME_____

EMAIL_____

BIRTHDATE_____SOCIAL SECURITY #_____

ADDRESS_____

EMPLOYER_____ OCCUPATION_____

DENTAL INSURANCE PROVIDER_____

SPOUSE/PARENT NAME_____

SPOUSE EMPLOYMENT_____

IN CASE OF EMERGENCY,CONTACT_____PHONE_____

ARE YOU UNDER A DOCTORS CARE?_____DOCTORS NAME_____

YOUR CURRENT MEDICATIONS_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS?_____

DO YOU TAKE ANY BLOOD THINNERS? *Yes or No* **WARFARIN COUMADIN PLAVIX PRADAXA AGGRENOX EFFIENT XARELTO ELIQUIS**

ANY OSTEOPOROSIS MEDICATION? *Yes or No* **FOSAMAX DIDRONEL BONIVA AREDIA ZOMETA RECLAST OTHER**

DO YOU HAVE ANY ARTIFICAL HIPS, KNEES, OR HEART VALVES?_____YEAR PLACED_____

ARE YOU ALLERGIC TO THE FOLLOWING? **LATEX PENICILLIN KEFLEX CECLOR SULFA OTHER (CIRCLE)**_____

HAVE YOU EVER HAD SURGERY AND WHY?_____

DO YOU USE ANY FORM OF TOBACCO AND WOULD YOU LIKE HELP QUITTING?_____

DO YOU HAVE ANY JAW JOINT PAIN?_____DO YOU GRIND YOUR TEETH?_____

DO YOU HAVE A BITE GUARD_____HAVE YOU HAD BRACES?_____

DO YOU HAVE ANY PAIN IN YOUR HEAD /NECK/TMJ AREA?_____WHEN?_____HOW OFTEN?_____

WHEN WAS YOUR LAST CLEANING?_____WHO WAS YOUR LAST DENTIST?_____

HAVE YOU EVER BEEN TREATED FOR GUM DISEASE (PERIODONTAL DISEASE)?_____

ARE YOU INTERESTED IN COSMETIC DENTISTRY? **TOOTH WHITENING PORCELAIN VENERRS MINOR TOOTH MOVEMENT PORCELAIN CROWNS SMILE DESIGN**

ARE YOU HAVING ANY DENTAL PAIN TODAY?_____WHERE?_____

HOW LONG HAVE YOU HAD THIS PAIN?_____

RATE THIS PAIN ON 1-10 SCALE_____HAVE YOU TAKEN PAIN RELIEVERS FOR THIS PAIN?_____

TODAYS

DATE:_____*SIGNATURE*_____