Please Print **Date:** ____________

Who May We Contact In An Emergency?
Name: ____________ Phone: ____________

NEW PATIENT INFORMATION

NOTE TO PATIENT: These questions are for your benefit. They assure that any dental treatment in the future will take into consideration your past and present health status. Please fill out these forms.

Name: ____________ Birth Date: ____________
Address: ____________ Height: ____________ Weight: ____________
City: ____________ ZIP: ____________ Whom may we thank for referring you? ____________
Home Phone: ____________ Cell: ____________ Regular Dentist: ____________
Business Phone: ____________ For How Long: ____________
Occupation: ____________ Insurance Company: ____________
Employer: ____________ Group Number: ____________
Business Address: ____________ Social Security Number: ____________
City: ____________ ZIP: ____________ Responsible Party: ____________
Marital Status: ____________
Spouse's Name (If Applicable): ____________
Spouse's Occupation: ____________
Chief Complaint: ____________

(OFFICE USE ONLY)
Date: ____________ Temperature: ____________
Blood Pressure: ____________ Heart Rate: ____________
ASA Class I II III IV: ____________
Reason: ____________

1) Have you come to this office for the relief of pain? YES___ NO___
If you are currently experiencing pain in your mouth, where is the pain? ____________

2) Are you currently taking any of the following? YES___ NO___
___ Antibiotics ___ Blood Thinner ___ Insulin
___ Arthritis medicine ___ Heart Medicine ___ Hormones
___ Birth Control Pills ___ Blood pressure medication ___ Steroids
Please list any medication you are taking that is not mentioned above: ____________

3) Do you have heart trouble? ____________ YES___ NO___
Do you wear a pacemaker? ____________ YES___ NO___
Do you have (or have ever had) any of the following? ___ Rheumatic heart ___ Heart murmur
___ Heart Attack ___ Chest pains on exertion ___ Rheumatic fever
Other ____________

4) Has a doctor ever said you had any of the following? (Check those which apply) YES___ NO___
___ Hepatitis ___ Lung Problem ___ High Blood Pressure ___ Venereal Disease
___ Tuberculosis ___ Anemia ___ Swollen ankles ___ Fainting or dizziness
___ Glaucoma ___ Cancer or Tumor ___ Goiter ___ Bad Nose Bleeds
___ Liver disorder ___ Epilepsy ___ Stroke ___ Pain in Chest
___ Prostate problem ___ Diabetes ___ Frequent Headaches ___ Stomach Trouble
___ Arthritis ___ Ulcers ___ Jaundice ___ Persistent Cough
___ Kidney Disorder ___ Low Blood Pressure ___ Shortness of Breath ___ Psychological Problems
___ ARC(AIDS Related Complex) ___ Measles ___ Thyroid Trouble
___ AIDS(Acquired Immune Deficiency Syndrome) ___ Prosthetic valve or joint replacement
___ Test Positive for antibodies to AIDS (Human T-Cell Lymphotrophic virus, Type 3 HTVL)

Have you ever taken:(Check those which apply) YES___ NO___
___ Aspirin ___ Nitroglycerin ___ Phen-Fen/Redux ___ Drugs for Sleep
___ Drugs for High Blood Pressure ___ Tranquilizers or Sedative ___ Anticoagulants
___ Antibiotics ___ Cortisone, Steroids ___ Insulin ___ Digitalis or Drugs for heart
___ Penicillin ___ Antihistamines ___ Sulfa Drugs ___ Thyroid Drugs

5) Do you have any disease, condition or problem not listed above that I should know about? YES___ NO___
If so, What ____________

6) Are you Pregnant? YES___ NO___

7) Do you wear contacts? YES___ NO___

8) Are you allergic, or have you experienced an unusual reaction to any of the following drugs/products? YES___ NO___
___ Penicillin ___ Codeine ___ Dental Anesthetic ___ Tylenol ___ Latex
___ Cortisone ___ Nitrous Oxide ___ Fluoride ___ Aspirin
___ Tetracycline Other Medicines ____________

9) Do you have an allergic Condition? YES___ NO___
___ Asthma ___ Skin rashes ___ Sinus Problems Others ____________

10) Have you had abnormal bleeding associated with extractions, surgery, or injury? YES___ NO___

11) Name of your physician: ____________

12) Date of last Physical examination: ____________ **Reason:** ____________
May we consult on your health history as needed? YES___ NO___

13) Have you ever been seriously ill or hospitalized? **YES__ NO__**
If so, Please Explain:____________________

14) Have you ever been treated for a growth or tumor? YES__ NO__
If so, where was it located and how were you treated? ____________________

15) Do you ever have seizures or convulsions? **YES__ NO__**
If so, When was the last time: ____________________

16) Do you have a tendency to faint? YES__ NO__
If so, when was the last time: ____________________

17) Is there a tendency toward any illness on both sides of your family? **YES__ NO__**
__Diabetes __Heart __Cancer __ Other ____________________

18) Has there been any change in your general health in the last year? YES__ NO__
If so, Please describe: ____________________

19) Have you ever had any injury to your face, jaws or teeth? **YES__ NO__**

20) When was your last visit to the dentist? ____________________

21) What was done? ____________________

22) When was the last time you had your teeth cleaned? ____________________

23) How often do you usually get your teeth cleaned?____________________

24) Are you happy with the appearance of your teeth? YES__ NO__
If not, what would you like changed: ____________________

25) How strongly do you feel about keeping your teeth? ____________________

26) Have you ever had sores in you mouth or lips that are slow to heal? YES__ NO__

27) Do you experience pain in your teeth because of heat, cold, or sweets? (Underline) **YES__ NO__**

28) Have you ever had periodontal (gum) treatments? YES__ NO__

29) Have you had previous orthodontic treatment? **YES__ NO__**
Oral Surgery? **YES__ NO__**

30) Have you ever had your teeth ground or your bite adjusted? YES__ NO__

31) Have you ever worn a bite plane or other appliance? **YES__ NO__**

32) Do your gums bleed easily? YES__ NO__

33) Do you feel that your gums are swollen? **YES__ NO__**
If so, Where:____________________

34) Do you get bad tastes in your mouth? YES__ NO__

35) Do you notice unusually bad odors from your mouth? **YES__ NO__**

36) Do you notice any loose teeth? YES__ NO__

37) Do you have any difficulty in chewing? **YES__ NO__**

38) Have you noticed your front teeth separating? YES__ NO__

39) Have you noticed spaces forming between your teeth? (Receding gums?) **YES__ NO__**

40) Do you smoke? Amount: ____________________ YES__ NO__

41) Are you aware of grinding your teeth together in the daytime? At Night? (Underline) **YES__ NO__**

42) Do you awaken in the morning with your teeth clenched together? YES__ NO__

43) Do you have frequent Headaches? **YES__ NO__**
If so, Do you wake up with them:____________________

44) Do you have the following symptoms? (Underline) YES__ NO__
___Tired or sore jaw muscles?___Ache in the face?___Ache in the Jaw? ___ Clicking of the jaw?

45) Do you have difficulty in opening your mouth wide? In Closing? (Underline) **YES__ NO__**

46) Do you mouth breathe while awake or asleep? (Underline) YES__ NO__

47) Is your tongue sore? **YES__ NO__**

48) Do you have a sensation of burning or dryness in your mouth? YES__ NO__

49) Are you worried about receiving dental treatment? **YES__ NO__**
If so, What is your main concern: ____________________

50) Have you ever had a bad experience in a dental office? YES__ NO__
If so, Please explain: ____________________

I acknowledge that all of the questions above have been carefully and accurately answered. If I ever have any change in my health or medication, I will inform Dr. Anderson without fail.

Please Sign Here: ____________________ **Date:** __________