About You

PATIENT ID # _____

Name: _____ Date: _____

I prefer to be called: _____ ◯ Female ◯ Male

Home address: _____
Street

_____
City State Zip

Birth Date: _____ Social Security Number: _____

Marital Status: ◯ Single ◯ Married ◯ Other

Employer: _____ Present Occupation: _____

Business Address: _____
Street City State Zip

Name of Spouse: _____

Spouse's Employer: _____

Name of Dependents: _____

Who may we thank for referring you: _____

Telephone Information

Home phone: _____ Business phone: _____

Email address: _____ Cell phone: _____

In case of emergency contact: _____ Relationship: _____

Home phone: _____ Cell phone: _____

For Patients with Dental Insurance

Primary Dental Insurance Policy:

Name of Insurance Co.: _____

Insurance Claim Address: _____

_____

Group Number/
Subscriber ID #: _____

Policyholder's Name: _____

Policyholder's SSN: _____

Policyholder's DOB: _____

Secondary Dental Insurance Policy:

Name of Insurance Co.: _____

Insurance Claim Address: _____

_____

Group Number/
Subscriber ID #: _____

Policyholder's Name: _____

Policyholder's SSN: _____

Policyholder's DOB: _____

Health History

Name of physician: _____ Phone: _____

Date of last visit: _____ Current health: ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Have you had any serious health problems in the last 5 years? ◯ yes ◯ no If yes, please explain:

(For Women) Are you currently pregnant:	◯ yes ◯ no	If yes, how many months?	_____
Are you taking birth control pills?	◯ yes ◯ no	Are you nursing?	◯ yes ◯ no

Do you have any allergies to any of the following (please circle): Aspirin Penicillin or other antibiotics Local Anesthetics Barbiturates, Sedatives, or sleeping pills Sulfa Drugs Codeine or other narcotics

Metals Latex (rubber) Iodine Hay fever/seasonal Animals Food Other: _____

The following conditions require a pre-medication. Please check any that apply to you now or have in the past:

◯ Artificial (prosthetic) heart valve ◯ Previous infective endocarditis

◯ Damaged valves in transplanted heart ◯ Congenital heart disease (CHD)

◯ Artificial Joint or implant in the last 2 years If so, date: _____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ◯ yes ◯ no

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent or Bisphosphonates (like Aredia,Zometa,XGEVA,Boniva,or Fosamax) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? ◯ yes ◯ no

Do you use controlled substances (drugs)? ◯ yes ◯ no If yes, list and date of last use: _____

Do you use tobacco (smoking, snuff, chew, bidis, vaping)? ◯ yes ◯ no If yes, how interested are you in stopping? (circle one) VERY/SOMEWHAT/NOT INTERESTED

Do you drink alcoholic beverages? ◯ yes ◯ no If yes, how much in the last 24 hours? _____

Do you use Marijuana? ◯ yes ◯ no If yes, how much in the last 24 hours? _____

Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours? ◯ yes ◯ no

Please list all medications and purpose of each:

Drug:	Dose:	Reason:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate if you have or have had any of the following diseases or medical problems:

Cardiovascular (heart) Disease	◯ yes ◯ no	Congestive Heart Failure	◯ yes ◯ no
Angina	◯ yes ◯ no	Damaged heart valves	◯ yes ◯ no
Heart Attack	◯ yes ◯ no	Heart Murmur	◯ yes ◯ no
Low blood pressure	◯ yes ◯ no	High blood pressure	◯ yes ◯ no
Bruise easily	◯ yes ◯ no	Mitral valve prolapse	◯ yes ◯ no
Pacemaker	◯ yes ◯ no	Rheumatic fever	◯ yes ◯ no
Rheumatic heart disease	◯ yes ◯ no	Abnormal bleeding	◯ yes ◯ no
Anemia	◯ yes ◯ no	Blood Transfusion	◯ yes ◯ no
Hemophilia	◯ yes ◯ no	Aids or HIV infection	◯ yes ◯ no
Arthritis/Gout	◯ yes ◯ no	Autoimmune Disease	◯ yes ◯ no
Rheumatoid arthritis	◯ yes ◯ no	Dementia/Alzheimer's	◯ yes ◯ no
Asthma	◯ yes ◯ no	Bronchitis	◯ yes ◯ no
Emphysema	◯ yes ◯ no	Sinus trouble	◯ yes ◯ no
Tuberculosis	◯ yes ◯ no	Cancer/Chemo/Radiation	◯ yes ◯ no
Chest pain upon exertion	◯ yes ◯ no	Chronic pain	◯ yes ◯ no
Diabetes Type I or II	◯ yes ◯ no	Eating Disorder	◯ yes ◯ no
Malnutrition	◯ yes ◯ no	Gastrointestinal disease	◯ yes ◯ no
G.E. Reflux/persistent heartburn	◯ yes ◯ no	Ulcers	◯ yes ◯ no
Thyroid problems	◯ yes ◯ no	Stroke	◯ yes ◯ no
Glaucoma	◯ yes ◯ no	Hepatitis, Jaundice, or liver disease	◯ yes ◯ no
Epilepsy	◯ yes ◯ no	Fainting spells or seizures	◯ yes ◯ no
Neurological disorders	◯ yes ◯ no	Sleep disorders	◯ yes ◯ no
Do you snore or have sleep apnea?	◯ yes ◯ no	Mental Health disorders	◯ yes ◯ no
Recurrent infections	◯ yes ◯ no	Kidney problems	◯ yes ◯ no
Night sweats	◯ yes ◯ no	Osteoporosis	◯ yes ◯ no
Persistent swollen glands in neck	◯ yes ◯ no	Severe headaches/migraines	◯ yes ◯ no
Severe or rapid weight loss or gain	◯ yes ◯ no	Sexually transmitted disease	◯ yes ◯ no
Excessive urination	◯ yes ◯ no	Tumor	◯ yes ◯ no
High Cholesterol	◯ yes ◯ no		

Please state any condition, disease, or problem not listed that you think I need to know about: _____

Office use only:

Notes:

Dental Information

Do your gums bleed when you brush or floss?	◯ yes ◯ no	Have you had periodontal (gum) treatments?	◯ yes ◯ no
Is your mouth dry?	◯ yes ◯ no	Have you had orthodontic (braces) treatment?	◯ yes ◯ no
Are your teeth sensitive to hot, cold, sweets, or pressure?	◯ yes ◯ no	Is your home water supply fluoridated?	◯ yes ◯ no
Have you had any problems associated with previous dental treatment?	◯ yes ◯ no	Do you drink bottled or filtered water?	◯ yes ◯ no
Do you have earaches or neck pains?	◯ yes ◯ no	Do you brux, clench or grind your teeth?	◯ yes ◯ no
Do you have any clicking, popping, or discomfort in the jaw?	◯ yes ◯ no	Do you have any sores or ulcers in your mouth?	◯ yes ◯ no
Do you have dentures or partials?	◯ yes ◯ no	Do you participate in recreational activities?	◯ yes ◯ no
Have you ever had a serious injury to your head or mouth?	◯ yes ◯ no	If yes, when:	_____
Are you currently experiencing any dental pain or discomfort?	◯ yes ◯ no	Date of last dental x-rays:	_____

Date of your last dental exam: _____ What was done at that time? _____

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take because of errors or omissions that I may have made in the completion of this form. If there is any change in my medical status, I will inform Dr. Etheridge and/or the staff.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist/Hygienist: _____ Date: _____

Notes: