Last Name ______________________ **First** ____________________ **Middle** ____________

Address Home ____

Phone Home ________________ Cell ________________ Work ______________

D.O.B. Month__________ Day__________ Year__________ S.S.# ________________

Occupation __________________________ **Employer** __________________________

Marital Status S/M/W/D **Spouses/Parents Name** ______________________

Dental Insurance 1.____________________ Group# ______________________

2.____________________ Group# ______________________

Medical Insurance ____________________ Group# ______________________

Referral Source Doctor____________ Patient ____________ Other ____________

Dental History (check all that apply)

- ☐ Regular Dental Care
- ☐ Dental Anesthesia/Sedation
- ☐ Dental Anxiety
- ☐ Specific Concerns
- ☐ Periodontal (gum) Therapy
- ☐ Bleeding/Sore Gums
- ☐ Food Impaction (traps)
- ☐ TMJ Disorders
- ☐ Cosmetic/Bleaching Therapy
- ☐ Content with Esthetics
- ☐ Dental Implants
- ☐ Missing Teeth Replaced
- ☐ Content with Function
- ☐ Sore/Sensitive Teeth
- ☐ Clenching/Grinding

Medical History (check all that apply)

- ☐ Good Overall Health
- ☐ Hospitalized/Operations
- ☐ Tobacco Use
- ☐ Alcohol Consumption
- ☐ Heart Conditions
- ☐ Vascular Conditions
- ☐ Breathing Disorders
- ☐ Neurological Conditions
- ☐ Infectious Diseases
- ☐ Bleeding Disorders
- ☐ Musculoskeletal Disorders
- ☐ Diabetes/Endocrine
- ☐ Cancer/Tumor
- ☐ Liver Disorder
- ☐ Kidney Disorder
- ☐ Gastrointestinal Disease
- ☐ Prostheses (artificial parts)
- ☐ Pregnancy/Nursing
- ☐ Limited Activities

Medications ____

Allergies ____

Height ________________________________ Weight ____________________

Medical Doctor(s) ______________________________ Phone ____________________

ASA Classification ____

____ Date ____________________