Patient Information

Soc.Sec._____ Date_____

Name _____ (M/F) Birth date _____ Home Ph._____ Cell Ph._____
Address _____ City_____ State_____ Zip_____
Circle one: Minor Single Married Divorced Widowed Separated
Patient's or Parent's employer _____ Work Ph._____
Business address _____ City_____ State_____ Zip_____
Spouse or Parent's name _____ Employer_____ WorkPh._____
Primary care Physician _____ Phone #_____
Other Physician(s) _____ Phone #_____
Emergency contact _____ Phone #_____
Email _____

Patient Medical History

	YES	NO
1. Are you allergic to or have you ever had any reactions to the following?		
a) Local anesthetics (e.g. Lidocaine)	O	O
b) Penicillin	O	O
c) Sulfa drugs	O	O
d) Codeine	O	O
e) Aspirin	O	O
f) Other (list) _____	O	O
2. Have you ever been hospitalized for any surgical operation or serious illness?	O	O
Reason _____		

	YES	NO
3. Are you taking any medication(s) including non-prescription medicine	O	O
Please list: _____		
4. Are you under medical treatment now?	O	O
Reason: _____		
5. Women ONLY:		
a) Are you pregnant, think you may be pregnant?	O	O
b) Are you nursing?	O	O
c) Are you taking birth control pills	O	O

6. Do you have or have you had any of the following?

	YES	NO
High Blood Pressure	O	O
Heart Attack	O	O
Rheumatic Fever	O	O
Swollen Ankles	O	O
Fainting / Seizures	O	O
Asthma	O	O
Low Blood Pressure	O	O
Epilepsy / Convulsions	O	O
Leukemia	O	O
Diabetes	O	O
Kidney Disease	O	O
Jaundice	O	O
AIDS or HIV Infection	O	O
Thyroid Problem	O	O

	YES	NO
Heart Disease	O	O
Cardiac Pacemaker	O	O
Heart Murmur	O	O
Angina	O	O
Frequently Tired	O	O
Emphysema	O	O
Cancer	O	O
Arthritis	O	O
Joint Replacement / Implant	O	O
Hepatitis (circle one) A B	O	O
Hepatitis C	O	O
Hepatitis D	O	O
Sexually Transmitted Disease	O	O
Stomach Troubles / Ulcers	O	O

	YES	NO
Chest Pains	O	O
Easily Winded	O	O
Stroke	O	O
Hay Fever / Allergies	O	O
Tuberculosis	O	O
Radiation Therapy	O	O
Glaucoma	O	O
Recent Weight Loss	O	O
Liver Disease	O	O
Heart Trouble	O	O
Anemia	O	O
Respiratory Problems	O	O
Other	O	O
(Explain)_____		

Patient Dental History

	YES	NO
1. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	O	O
b) Pain (joint, ear, side or face)	O	O
c) Difficulty in opening or closing?	O	O
d) Difficulty in chewing?	O	O

	YES	NO
2. Do you have frequent headaches?	O	O
3. Do you clench or grind your teeth?	O	O
4. Have you ever had any head, neck or jaw injuries?	O	O
5. Do you have any sores lumps in or near your mouth?	O	O
6. Do your gums bleed while brushing or flossing?	O	O

B. Do you snore or have been told you snore?	O	O
Do you have trouble breathing through?		
Your nose?	O	O
Do you sleep well?	O	O
Have you been diagnosed with sleep apnea?	O	O
Have you had a sleep study?	O	O