



PATIENT INFORMATION

Name _____
(Last) (First) (Middle)

Address _____

(City) (State) (Zip)

Birthdate / / _____ Email Address _____

Employer _____ Occupation _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Who is your physician? _____

Who is you general dentist? _____ Date of last cleaning? / / _____

Referred by _____

EMERGENCY INFORMATION

Name _____
(Last) (First) (Middle)

Address _____

Email Address _____

Previous Address (if less than 3 years) _____

S.S. # _____ Birthdate / / _____

Relationship to Patient _____

Employer _____ Occupation _____

Home Phone () _____ Work Phone () _____

No. of Years Employed _____

Spouse's Employer _____

Spouse's Occupation _____ Work Phone () _____

RESPONSIBLE PARTY INFORMATION

Name of the nearest relative not living with you. _____

Name _____
(Last) (First) (Middle)

Address _____

Phone () _____

I understand that where appropriate, credit bureau information may be obtained. _____



Patient's Name _____

Signature _____

Date / / _____

I. SUBJECTIVE COMPLAINTS AND CONCERNS

A. What are the patients or parents main concerns regarding the jaws and teeth?

	MILD	MODERATE	SEVERE
<input type="checkbox"/> Facial Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gum Disease/ Recession	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gum Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Jaw Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Jaw Joint Sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ringing/Stuffiness of Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bad Bite			
<input type="checkbox"/> "Buck" Teeth			
<input type="checkbox"/> Crowding			
<input type="checkbox"/> Crossbite			
<input type="checkbox"/> Gummy Smiles			
<input type="checkbox"/> Impacted Teeth			
<input type="checkbox"/> Irregular Facial Proportions			
<input type="checkbox"/> Irregularly Shaped Teeth			
<input type="checkbox"/> Missing Teeth			
<input type="checkbox"/> Mouth Too Small			
<input type="checkbox"/> Openbite			
<input type="checkbox"/> Overbite			
<input type="checkbox"/> Prominent Lower Jaw			
<input type="checkbox"/> Protrusion of Teeth			
<input type="checkbox"/> Recessive Lower Jaw			
<input type="checkbox"/> Small Teeth			
<input type="checkbox"/> Spaces			
<input type="checkbox"/> Underbite			
<input type="checkbox"/> Other			

B. Family members with similar problems?

- Father Mother Brother
- Sister Other

II. MEDICAL DENTAL HISTORY

A. Present Health	Good	Fair	Poor
Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Under Stress	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

B. Has the patient reached puberty? Yes No

C. Has the patient ever had any of the following conditions?

- Allergies
- Arteriosclerosis
- Asthma
- Autoimmune Disorder
- Blood Disease
- High Blood Pressure
- Low Blood Pressure
- Bone Disorders
- Cancer
- Diabetes
- Dizziness
- Emotional Problems
- Endocrine Problems
- Epilepsy
- Hearing Disorders
- Heart Disease
- Heart Murmur
- Hepatitis
- HIV/AIDS/ARC (Circle)
- Kidney Disease
- Rheumatic Fever
- Ringing of Ears
- Sleep Disturbance
- Trauma (to face, teeth, jaws, or head)
- Other

D. Medication. Current medications taken by the patient?

- Do you take antibiotics before dental cleanings?
- Antibiotics
- Birth Control Pills
- Diet Pills (diuretics)
- Heart Pills (digitalis, etc.)
- Insulin
- Muscle Relaxants (valium, etc.)
- Pain Pills (Demerol, codeine, etc.)
- Sleeping Pills
- Tranquilizers (elavil, valium, etc.)
- Vitamins
- Other

