



1957 Raymond Diehl Rd. • Tallahassee, FL 32308 • (850) 385-2003

Patient Information

Patient Name: _____ Nickname: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home: _____ Work: _____ Cell: _____
DL#: _____ SS#: _____ Birthdate: _____
Marital Status: Single Married Divorced Widowed Sex: Male Female
Email: _____ (Used for appointment reminder and in-office use only)
Employed by: _____ Occupation: _____
Spouse Name: _____ Occupation: _____
Spouse Employed by: _____ Work Phone: _____
Name of person responsible for account: _____ Relationship: _____
Address of responsible party: _____
Home: _____ Work: _____ Cell: _____

Insurance

(Please provide a copy of your insurance card. Without the proper information we are not able to assist you in filing your Dental Insurance.)

Insurance Co. _____ Employer: _____
Insured Name: _____ DOB: _____ SS#: _____
Insured Address (if different from above): _____
City: _____ State: _____ Zip: _____

Dental History

Reason for today's visit? _____
Name of previous dentist: _____ Last dental visit? _____
Phone Number: _____ City: _____

	YES	NO
Do you feel apprehensive about having dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a bad experience in a dental office?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed or feel tender or irritated?	<input type="checkbox"/>	<input type="checkbox"/>
Are you sensitive to: (check one) <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Sweets <input type="checkbox"/> Pressure		
Are you aware of grinding or clenching your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have: (check one) <input type="checkbox"/> Loose <input type="checkbox"/> Tipped <input type="checkbox"/> Shifting Teeth?		
Have you worn braces on your teeth? (Orthodontics)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have discolored teeth that bother you?	<input type="checkbox"/>	<input type="checkbox"/>
Are you unhappy with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your smile to look better or different?	<input type="checkbox"/>	<input type="checkbox"/>
How do you feel about your teeth? _____		

Medical History

Family Physician _____ Phone _____

YES or NO

Are you presently in good health?

Are you under a physician's care now?

For what reason? _____

Are you currently taking any drugs or medications?

Please list: _____

Have you ever had excessive bleeding requiring special treatment?

Are you pregnant?

Do you use any type of tobacco product?

Do you use any type of blood thinner medication including aspirin?

Do you take any drugs for Osteoporosis to prevent bone loss or IV bisphosphonates?

Please check any of the following you are allergic to or have had adverse reactions to:

- | | | | |
|----------------------------------|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Percodan | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Penicillin | |

Please check any of the following which you have had or have at the present:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS or HIV Positive | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Previous Orthodontic |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Arthritis/Rheumatoid | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Joint/Implants | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Metal Allergies | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Swallowing Problems |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervousness Problems | <input type="checkbox"/> TMJ Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease/Attack | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Clenching/Grinding Teeth | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Popping Jaw Joints | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Previous Gum Disease | |

Any other medical problem you are having that is not listed? _____

To the best of my knowledge, all of the above answers are true and correct. If I ever have a change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail:

Patient/Guardian Signature: _____ Date: _____