

Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
First M.I. Last

Age \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ email \_\_\_\_\_

Address \_\_\_\_\_
Street City State Zip

Current / Former Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Phone \_\_\_\_\_
Company Address

Name \_\_\_\_\_ Who to contact in \_\_\_\_\_ Contact \_\_\_\_\_
of spouse \_\_\_\_\_ case of emergency: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_
First Last

Physician \_\_\_\_\_ Dental insurance? Y N Referred by: \_\_\_\_\_
Name City Phone

Medical History Do you now or have you ever had any of the following diseases or medical conditions?

Please circle your answer for all questions.

- y n Heart Disease / Bypass Surgery / Stent
y n Heart Valve Disorder / Replacement
y n Artificial Joint Replacement
y n High / Low Blood Pressure
y n Osteoporosis
y n Emphysema / Asthma
y n Liver Disorder / Hepatitis - A, B, C
y n Rapid Weight Change - Eating Disorder
y n Alcohol or Drug Dependency
y n Sinus Problems / Hay Fever
y n Nervous Disorder
y n Epilepsy / Seizures
y n Use tobacco? Smoke? \_\_\_ packs /day
y n Hospitalizations in the last 2 years? For what care?
y n Heart Attack / Angina
y n Heart Murmur
y n Diabetes Type I Type II
y n Bleeding Disorder / Abnormal Bleeding
y n Arthritis
y n Thyroid Disorder
y n Stomach Disorder / Ulcers
y n Psychiatric Therapy
y n Herpes / Shingles
y n TMJ Disorder or Therapy
y n HIV Positive / AIDS
y n Radiation or Chemotherapy
y n Allergy: Latex, Metal, Acrylic
When?
y n Stroke
y n Rheumatic Fever
y n Pacemaker
y n Tuberculosis (TB)
y n Respiratory Disease
y n Kidney Disorder
y n Alzheimer's Disease
y n Sleep Disorder
y n Lupus
y n Frequent Headaches
y n Parkinson's Disease
y n Cancer
y n Currently Pregnant?

Please list all current medications:

Please list any allergies to medications:

Please list any other medical condition:

Dental History Please answer all questions.

How would you describe your current dental problem? \_\_\_\_\_

On a scale of 1-10 (with 10 being ideal), how would you rate your dental health? (poor) 1 2 3 4 5 6 7 8 9 10 (ideal)

- y n Would you like whiter teeth?
y n Are there any concerns about the appearance of your teeth? What?
y n Have you ever been diagnosed as having periodontal disease? When? Treatment:

Date of last dental visit: \_\_\_\_\_ Care: \_\_\_\_\_ Brush \_\_\_/ day Floss \_\_\_/ day

Teeth sensitivity to: Heat? Cold? Biting pressure? Sweets? Inability to chew properly? Swelling? Dry mouth?

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence. I affirm that it is my responsibility to inform this office of any changes in my medical status.

X \_\_\_\_\_
Patient's Signature Date

Office Use Only:
Systemic/Prognosis Factors: Health Medications Smoking Physical Ability Habits Homecare Other:
Reviewed by: \_\_\_\_\_ Vita 3D Shade \_\_\_/\_\_\_ Classic Shade: \_\_\_/\_\_\_ Notes:
initials date

