

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

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: _____
initial date