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Louisville, KY
New Albany, IN

E-Mail: ____________________
Cell Phone: ____________________

Mr.
Ms.
Mrs. ______________________ Name you go by __________ Occupation __________
FIRST MIDDLE LAST

SS# __________ Home Phone __________ Work Phone __________
Street Address __________ City __________ State ______ Zip ______
(for office use only) Updated Address ____________________
Birthdate __________ Age ______ Marital Status __________
Employer __________ City __________ State ______ Zip ______
Spouse Name __________ Occupation __________
Employer __________ City __________ State ______ Zip ______
Regular Dentist __________ No. of yrs. ______ Referred by __________
If patient is a minor, provide guardian name, address, work and home phone #, and SS# __________
Do you have dental insurance? ❑ YES ❑ NO

DENTAL HEALTH HISTORY

1. Why are you visiting our office? ____________________
2. Has your dental care been ______ Regular (every 6 mos.) ______ Intermittent (when necessary) ______ Infrequent (pain)
3. Approximate date of last visit __________ for: ❑ check-up ❑ treatment ❑ cleaning ❑ emergency
4. Have you ever had Periodontal care? ❑ YES ❑ NO If yes, when? __________
   Have you ever had Orthodontic care (Braces)? ❑ YES ❑ NO If yes, when? __________
5. If you have partial dentures or full dentures, are you satisfied with them? ❑ YES ❑ NO If no, why not? __________
6. Are you satisfied with the appearance of your teeth? ❑ YES ❑ NO If no, why not? __________
7. Are you experiencing any of the following?
   ______ Bad breath or taste
   ______ Bleeding gums
   ______ Drifting of teeth
   ______ Food packing between teeth
   ______ Foul odor
   ______ High or rough fillings
   ______ Loose teeth
   ______ Pain/soreness in gums
   ______ Pus around the teeth
   ______ Receding gums
   ______ Spaces between teeth
   ______ Swelling of gums
8. Is there any sensitivity in your teeth to:
   ______ Hot
   ______ Cold
   ______ Sweets
   ______ Biting/chewing
   ______ Tooth brushing
   ______ Flossing
   ______ Current dental appliances
9. Do you habitually grind or clench your teeth? ❑ YES ❑ NO __________
10. Do you suffer from pain in the face, neck, ears, jaws? ❑ YES ❑ NO __________
11. Have you ever had an injury to your face, neck, or jaws? ❑ YES ❑ NO __________
12. Are you presently having oral or facial pain? ❑ YES ❑ NO __________

(OVER)

FOR OFFICE USE

B.P. __________ Med. Consult __________ Dental Consult __________
M.D. ____________________
D.M.D. ____________________
Medical Alert ____________________

MEDICAL HEALTH HISTORY

The following questions are pertinent to the treatment of your periodontal/implant condition. Please answer all questions. All answers are confidential.

1. How is your general health? ______________________________
2. Physician name(s) and address ______________________ Specialty ______________
3. Date of last physical examination and type of subsequent treatment: ______________
4. Are you currently undergoing any _____medical or _____physical care?______________
5. Have you been _____seriously ill or _____hospitalized? If yes, explain:______________
6. Are you HIV positive or do you have AIDS? ❏ YES ❏ NO If yes, please give dates and attending Physician: ______________

   ____

7. Are you taking any of these medications?

______Antibiotics	______ Birth control pills	_______Heart medicine	_______ Tranquilizers
______Blood thinner	______ Blood pressure	_______Hormones	_______ Antihistamines
______Aspirin products	______ Cortisone steroids	_______Insulin	_______ Other

8. Do you have or have you had any of the following? ______________________________

______Anemia	______ Epilepsy	_______Heart trouble	_______ Ulcers
______Arthritis	______ Glaucoma	_______Kidney disorder	_______ X-Ray therapy
______Asthma	______ Heart attack	_______Liver disorder	_______ Artificial joints
______Cancer or tumor	______ Rheumatic fever	_______Hepatitis	_______ Prolapsed Mitral Valve
______Chemotherapy	______ Heart murmur	_______Stroke	
______Chest pain	______ Persistent cough	_______Thyroid problems	
______Diabetes	______ Heart surgery	_______Tuberculosis	

9. Have you had abnormal bleeding associated with extractions, surgery, or trauma?______________

   ____

10. Do you have any allergies? ❏ YES ❏ NO If so, allergy to: ______________________
11. Have you had unusual reaction to:

______Aspirin	______ Erythromycin	_______Nitrous Oxide	_______ Tylenol
______Amoxicillin	______ Flagyl	_______Oxycodone	_______ Valium
______Augmentin	______ Hydrocodone	_______Penicillin	_______ Vicodin (Lortab)
______Barbituates	______ Halcion	_______Percodan	_______ Other
______Codeine	______ Ibuprofen (Advil)	_______Sulfa	
______Dental Anesthetic	______ Keflex	_______Tetracycline	

12. Do you smoke? Yes No
13. If yes, what type? ❏ Tobacco ❏ Vaping ❏ Marijuana ❏ Other ______________________
14. Do you use any smokeless tobacco products? ❏ YES ❏ NO If Yes, which products & how much? ______________
15. Do you drink more than one alcoholic beverage per day routinely? ❏ YES ❏ NO
16. Are you recovering from ❏ Alcohol dependency ❏ Substance abuse Please list ______________
17. Do you have any other medical problems we should know about? ❏ YES ❏ NO ______________

    ____

18. If you are a female, are you pregnant? ❏ YES ❏ NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or medications, I will inform this office at my next appointment.

____

Signature of Patient **Date**