Welcome to
The Dental Group

PATIENT INFORMATION

Date_____

Name_____ **Home Phone** _____

Address_____ **Cell Phone** _____

City_____ **Work Phone**_____

State and Zip code_____ **Email** _____

Birth Date_____ **SSN #**_____

Circle: Male Female

DENTAL HISTORY

Former Dentist_____Phone_____

Address_____

Approximate date of last dental appointment_____

Please check (√) if you have had any problems with the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping of jaw
- ☐ Grinding teeth
- ☐ Loose teeth
- ☐ Lost filling or crown
- ☐ Sensitivity to hot or cold
- ☐ Sores or growth in mouth

Have you ever had excessive or prolonged bleeding following a tooth extraction or other injury? Yes ☐ No ☐

Have you ever had trouble associated with previous dental treatment? Yes ☐ No ☐

Have you ever experienced dizziness, fainting, or reaction to the Novocaine? Yes ☐ No ☐

Are you wearing a removable dental appliance? Yes ☐ No ☐

If yes, how old is appliance? _____

MEDICAL HISTORY

Physician's Name_____Phone Number_____

Date of last visit_____Have you had any serious illness or operations? Yes ☐ No ☐

If yes, please specify_____

Are you currently taking any medications? Yes ☐ No ☐

If yes, please list all medications: _____

_____

Do you have any allergies to medicine? Yes ☐ No ☐

If yes, please list all allergies: _____

_____

Women: Are you pregnant? Yes ☐ No ☐

If yes, how many months? _____

Nursing? Yes ☐ No ☐

Taking birth control pills? Yes ☐ No ☐

Please check (√) if you have had any of the following:

- ☐ Aids/HIV Positive
- ☐ Artificial Heart Valve/Joints
- ☐ Cancer
- ☐ Diabetes
- ☐ Chemical Dependent
- ☐ Latex Allergy
- ☐ Other_____
- ☐ Arthritis
- ☐ Tobacco Habit
- ☐ Thyroid Disease
- ☐ Herpes
- ☐ Stroke
- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ Hepatitis
- ☐ Bleeding Disorders
- ☐ Rheumatic Fever
- ☐ Epilepsy
- ☐ Pace Maker
- ☐ Venereal Disease
- ☐ Persistent Cough
- ☐ Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ Syphilis
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Asthma
- ☐ Sinus Problems
- ☐ Psychiatric Treatment
- ☐ Low Blood Pressure

How did you hear about us? Please specify _____

The information given above is accurate to the best of my knowledge. I understand this information will be used by the dentist to help determine the appropriate dental treatment. If there is any change in my medical information, I will inform the dentist.

Patient Signature (Parent or Guardian if minor) _____**Date**_____

Doctor's signature_____**Date**_____