



48959 Calcutta Smith Ferry Road, East Liverpool, OH 43920  
330.385.4126

PATIENT INFORMATION								
First Name:	Middle Name:	Last Name:			Nickname:			
Date of Birth:	Age:	Gender:	SSN:		Marital Status:			
Mailing Address:			City:	State:	Zip:			
Email Address:			Occupation:					
Employer:	Cell Phone:		Home Phone:		Work Phone:			
Employer Address:		Employer City:		State:	Zip:			
PREFERRED METHOD OF COMMUNICATION								
What is the best way to contact you?		Home Phone [ ]	Cell Phone [ ]	Text [ ]				
		Work Phone [ ]	Email [ ]	Other [ ]				
		Facebook [ ]						
INSURANCE POLICY HOLDER IF OTHER THAN PATIENT								
First Name:	Middle Initial:	Last Name:			SSN:			
Address:		City:			State:	Zip:		
Date of Birth:	Home Phone:		Cell Phone:					
Employer:								
Employer Address:		Employer City:		State:	Zip:			
PERSON TO CONTACT IN CASE OF EMERGENCY								
Contact Relationship:	First Name:		Last Name:					
Home Phone:	Cell Phone:		Employer Phone:					
Do you authorize this office to discuss your care or treatment with any party besides yourself: [ ] yes [ ] no								
Other Authorized Person(s) (if any):								
DENTAL INSURANCE INFORMATION								
Primary Insurance:			Employer:					
Policy Holder Name:		Date of Birth:		Policy Holder SSN:				
Insurance Address:			City:		State:	Zip:		
Phone Number:		Group Number:			Member ID:			
Secondary Insurance:			Employer:					
Policy Holder Name:		Date of Birth:		Policy Holder SSN:				
Secondary Ins Address:			City:		State:	Zip:		
Secondary Ins Phone Number:			Group Number:		Member ID:			

HOW DID YOU HEAR ABOUT OUR OFFICE? IS THERE SOMEONE WE CAN THANK FOR REFERRING YOU?							
Billboard [ ]	Friend [ ]	Name of referring friend:					
Doctor [ ]	Internet Search [ ]	Our Website [ ]	TV Commercial [ ]				
Facebook [ ]	Mobile App [ ]	Other Social Media [ ]	Yellow Pages [ ]				
IS THERE A FAMILY MEMBER FOR WHOM YOU WOULD LIKE TO SCHEDULE AN APPOINTMENT?							
Name:							

## MEDICAL HEALTH HISTORY

Although dental professionals primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems you may have or medications you may be taking could impact your oral health and may have an important relationship with your dental care.

Thank you for answering the following questions:

Do you have or have you had an of the following? **Please circle all that apply.** If necessary, use the back of the form to explain.

- |                           |                           |                       |                            |
|---------------------------|---------------------------|-----------------------|----------------------------|
| Acid Reflux/GERD          | Cortisone Medication      | Hepatitis B or C      | Rheumatism                 |
| AIDS/HIV Positive         | Diabetes                  | Herpes                | Scarlet Fever              |
| Alzheimer's Disease       | Drug Addiction            | High Blood Pressure   | Shingles                   |
| Anaphylaxis               | Easily Winded             | High Cholesterol      | Sickle Cell Disease        |
| Anemia                    | Emphysema                 | Hives or Rash         | Sinus Trouble              |
| Angina                    | Epilepsy or Seizures      | Hypoglycemia          | Sleep Apnea                |
| Arthritis/Gout            | Excessive Bleeding        | Irregular Heartbeat   | Spina Bifida               |
| Artificial Heart Valve    | Excessive Thirst          | Kidney Problems       | Stomach/Intestinal Disease |
| Artificial Joint          | Fainting Spells/Dizziness | Leukemia              | Stroke                     |
| Asthma                    | Frequent Cough            | Liver Disease         | Swelling of Limbs          |
| Blood Disease             | Frequent Diarrhea         | Low Blood Pressure    | Thyroid Disease            |
| Blood Transfusion         | Frequent Headaches        | Lung Disease          | (Hypothyroid/Hyperthyroid) |
| Breathing Problems        | Genital Herpes            | Mitral Valve Prolapse | Tonsillitis                |
| Bruise Easily             | Glaucoma                  | Osteoporosis          | Tuberculosis               |
| Cancer                    | Hay Fever                 | Pain in Jaw Joints    | Tumors or Growths          |
| Chemotherapy              | Heart Attack/Failure      | Parathyroid Disease   | Ulcers                     |
| Chest Pains               | Heart Murmur              | Psychiatric Care      | Venereal Disease           |
| Cold Sores/Fever Blisters | Heart Pacemaker           | Radiation Treatments  | Lyme Disease               |
| Congenital Heart Disorder | Heart Trouble/Disease     | Recent Weight Loss    |                            |
| Convulsions               | Hemophilia                | Renal Dialysis        |                            |
| Yellow Jaundice           | Hepatitis A               | Rheumatic Fever       |                            |

Any medical conditions not listed above: \_\_\_\_\_

## PHARMACY INFORMATION

Pharmacy name:	Address:	Phone:

Are you under a physician's care?	Yes	No	If yes, please explain:
Who is your primary care physician?	Name:		Phone#:
Do you have a cardiologist?	Name:		Phone#:
Have you had a joint replacement?	Date of surgery:		
Orthopedic Surgeon	Name:		Phone#:
Have you had an organ transplant?	Date of surgery:		
Surgeon	Name:		Phone#:
Have you ever been hospitalized or had a major operation?	Yes	No	Please list all surgeries and dates:
Have you ever had any serious head or neck injuries?	Yes	No	If yes, please explain:
Are you taking any medications, vitamins, or supplements?	Yes	No	Please list all medications and supplements:
Are you currently taking, or have you ever taken a medication for osteoporosis (Fosamax, Boniva, Actonel) or any other medications containing bisphosphonates?	Yes	No	
Are you taking any blood thinning medications such as Coumadin or Plavix?	Yes	No	
Are you on a special diet?	Yes	No	If yes, please explain:
Do you use controlled substances?	Yes	No	If yes, please explain:
Do you use tobacco?	Yes	No	

Are you allergic to any of the following?

- Aspirin                       Penicillin                       Codeine                       Acrylic  
 Metal                               Latex                               Sulfa Drugs     Local Anesthetics  
 Other Please List: \_\_\_\_\_

## WOMEN

Are you:

- |  |   |
|--|---|
| <input type="checkbox"/> Pregnant/Trying to get pregnant     | <input type="checkbox"/> Nursing                    |
| <input type="checkbox"/> Experiencing a late menstrual cycle | <input type="checkbox"/> Taking oral contraceptives |

## DENTAL HEALTH HISTORY

Date of last dental visit:	What was done at that visit?	
Date of last hygiene visit?	Date of last complete xrays?	
What is the most important thing to you about your future smile and dental health?		
What is your biggest concern related to your dental visit today?		
<b>ON A SCALE OF 1 -10, WITH 10 BEING THE HIGHEST, PLEASE RATE THE FOLLOWING:</b>		
How important is your dental health to you?	Where would you rate your current dental health?	
Where do you want your dental health to be?		
<b>IF I COULD CHANGE MY SMILE, I WOULD:</b>		
Make it whiter <input type="checkbox"/> yes <input type="checkbox"/> no	Close spaces <input type="checkbox"/> yes <input type="checkbox"/> no	Make it straighter <input type="checkbox"/> yes <input type="checkbox"/> no
Replace black, metal fillings with tooth-colored restorations <input type="checkbox"/> yes <input type="checkbox"/> no		Repair chipped teeth <input type="checkbox"/> yes <input type="checkbox"/> no
Replace old crowns that don't match <input type="checkbox"/> yes <input type="checkbox"/> no		Have a smile makeover <input type="checkbox"/> yes <input type="checkbox"/> no
Replace missing teeth <input type="checkbox"/> yes <input type="checkbox"/> no		
Are you experiencing any dental problems now <input type="checkbox"/> yes <input type="checkbox"/> no	If yes, please describe:	

## GENERAL DENTAL HISTORY

<p>1. Have you had:</p> <p>Regular preventive dental care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Gum treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Oral surgery treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bite (occlusion) treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Orthodontic care (braces)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Root canal treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dentures or bridgework? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Do you now have:</p> <p>A bite problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bleeding gums? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Gum pain or swelling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Food catching between teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any sensitive teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any toothaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bad breath? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loose or moving teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dry mouth problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>White areas in mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent cold sores or mouth sores/ulcers? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Can you:</p> <p>Chew your food effectively? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Talk and smile without worrying about your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bite without pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>4. Do you/your:</p> <p>Brush your teeth daily? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Floss your teeth daily? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clean your teeth in other ways? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Use your fluoride treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Use mouthwash? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Form tarter quickly? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Use a water pick? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Grind or clench your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have a concern over loosing teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chew mostly on one side? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eat a lot of sweets/sugary food? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Teeth interfere with your speech? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Like the appearance of your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Like the color of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Teeth break or fracture easily? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Wear a retainer, mouth appliances, brux splint or mouth guard? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you or have you ever experienced:</p> <p>Difficulty opening/closing jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty chewing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain in or discomfort in your jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clicking or popping of your jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain in or around your ear or the side of your face? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Jaw muscle tiredness or soreness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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**I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.**

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_