



**ARTHUR H.
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COSMETIC &
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DENTISTRY

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Master of the Academy of General Dentistry

Patient Information

Today's Date _____

Name: _____

Birthdate: _____ Age: _____ Social Security # _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone () _____ Work Phone () _____

E-mail: _____ Fax: _____

Place of employment: _____

If retired, previous employer(s): _____

Occupation: _____

Check appropriate status: Married Single Other

Spouse's name _____ Spouse's employer _____

Spouse's work phone number _____

In case of an emergency, who should be notified? _____

Relationship to you _____ Phone number _____

Whom may we thank for referring you? _____

Name of previous dentist _____ Phone number _____

Address _____

Person responsible for paying for this account? _____

Relationship to patient _____ Home Phone _____

continued on next page...

For your convenience, we offer the following methods of payment.
Cash Personal check Visa Mastercard AmEx

Patient Medical History

Name of Physician _____ Office Phone () _____

Date of last exam _____ Reason _____

Are you under medical treatment now? Yes No

If yes, please explain _____

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No

If so, please explain _____

Are you taking any medications? Yes No

Which prescription medications? _____

Which non-prescription? _____

Herbs? _____

Are you currently using nose sprays or inhalers? Yes No

What type? _____

Do you use tobacco? Yes No

Are you allergic to or have reactions to the following?

Local anesthetics Yes No

Penicillin or any other antibiotics Yes No

Sulfa drugs Yes No

Iodine Yes No

Aspirin Yes No

Any metals (eg. mercury, costume jewelry, etc) Yes No

Latex rubber Yes No

Other (please list) _____

Do you have or have you had any of the following?

- Heart Disease Yes No
- High Blood Pressure Yes No
- Heart Attack Yes No
- Chest Pains Yes No
- Angina..... Yes No
- Heart Murmur Yes No
- Cardiac Pacemaker Yes No
- Mitral Valve Prolapse Yes No
- Stroke Yes No
- Swollen Ankles Yes No
- Liver Disease Yes No
- Hepatitis Yes No
- HIV Infection Yes No
- Sexually Transmitted Disease..... Yes No

- Emphysema Yes No
- Hay Fever/Allergies Yes No
- Asthma Yes No
- Tuberculosis Yes No
- Arthritis Yes No
- Joint Replacement Yes No
- Breathing Problems Yes No
- Kidney Disease..... Yes No
- Diabetes Yes No
- Thyroid Problems..... Yes No
- Eye Problems Yes No
- Hearing Problems..... Yes No
- Cancer Yes No
- Radiation Therapy Yes No

Other (please list) _____

Women only:

Are you pregnant or think you may be pregnant? Yes No

Are you nursing? Yes No

Are you taking oral contraceptives? Yes No

continued on next page...

Patient Dental History

Do your gums bleed while brushing or flossing? Yes No

Are your gums red, swollen, or tender? Yes No

Are your gums pulling away from your teeth? Yes No

Are your permanent teeth loose or separating? Yes No

Has there been any change in the way your teeth fit together when you bite? Yes No

Are your teeth sensitive to hot or cold liquids or foods? Yes No

Do you feel pain in any of your teeth? Yes No

Do you have any sores or lumps in or near your mouth? Yes No

Have you had any neck, jaw, or head injuries? Yes No

Have you ever experienced any:

Pain or clicking in your jaw? Yes No

Difficulty opening or closing your mouth? Yes No

Do you clench or grind your teeth? Yes No

Have you ever had any difficult extractions in the past? Yes No

Have you ever had any prolonged bleeding following extractions? Yes No

Have you had any orthodontic treatment? Yes No

Do you wear dentures or partials? Yes No If so, date of placement _____

Is there any change in the fit of your partial or denture? Yes No

Do you have bad breath or bad taste in your mouth? Yes No

Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No

Do you like your smile? Yes No

Is there anything you would like to change about your teeth? _____

Do you like the color of your teeth? Yes No

How important is it for you to keep your teeth? Very important Somewhat important Not important