Welcome to Our Office!

Date ________________

Name ________________________________ Social Security No._______-_____-_______

Address ________________________________ City/State/Zip ________________________________

Age ____ Birthdate __________ Sex: M F Home # ______________ Bus. # ______________ Cell # ____________

Marital status (optional) ______________________________ Name of spouse ______________________________

Patient's Occupation ______________________________ Employer/School ______________________________

In case of emergency please notify: Name ______________________ Phone ______________________________

Physician's name and phone ______________________________ Date of last physical exam ________________

What is your present health? Good____ Fair___ Poor____ Are you having pain or discomfort at this time? Yes____ No____

Circle any of the following which have had or have at the present:

Heart attack or stroke	Lung disease	Liver disease	Anemia or hemophilia
Chest pains (angina)	Shortness of breath	Yellow jaundice	Blood transfusions
Heart surgery	Emphysema	Hepatitis A (infectious)	Bruise easily
Heart pacemaker	Asthma or hay fever	Hepatitis B (serum)	Sickle cell disease
High or low blood pressure	Fainting or dizzy spells	Hepatitis C	Kidney problems
Swelling of ankles	Tuberculosis (TB)	Diabetes	Epilepsy or seizures
Thyroid disease	Cortisone medication	Glaucoma	Arthritis or rheumatism
Pain in jaw or joints	Skin rashes or hives	Psychiatric treatment	Sexually transmitted disease
Cancer or tumor		Drug addiction	AIDS or HIV
Radiation therapy (x-ray, cobalt)		Alcoholism	Cold sores

Antibiotic premedication is required for patients who have had any of the following (please circle):

Prosthetic heart valves	History of SBE	Uncontrolled, unstable diabetes
Mitral valve prolapse	IHSS	Blood disease (particularly leukemia)
Heart murmur (at present)	Marfan's syndrome	Anti-cancer chemotherapy
Rheumatic fever	Synthetic valve grafts or stents	Aneurysms
Scarlet fever	Artificial joints	Facial trauma (at present)
Congenital cardiac malformations	Kidney transplant	Tooth extraction following radiation therapy

Circle

Do you have any diseases, conditions or problems not listed above? .... No Yes

If yes, please explain ________________________________

Are you presently taking any prescription medicine or drugs? .... No Yes

If yes, list drug, dosage and frequency: ________________________________

____

Are you presently taking any over the counter medications including vitamins or herbs? .... No Yes

If yes, list kind, dosage and frequency: ________________________________

Are you allergic to any medicine, drug or other substance? .... No Yes

If yes, please list: ________________________________

Are you now, or have you been under the care of a medical doctor during the last two years? .... No Yes

Have you ever been hospitalized or had surgery? .... No Yes

If yes, for what and when? ________________________________

Have you ever had a reaction to a local anesthetic (i.e. Novocaine)? .... No Yes

Have you ever had prolonged or unusual bleeding? .... No Yes

Have you ever had an injury or trauma to your face or jaw? .... No Yes

Do you smoke or use smokeless tobacco? .... No Yes

Have you ever had a skin reaction from jewelry? .... No Yes

WOMEN ONLY **Circle**

Are you pregnant? If yes, what is your due date? .... No Yes

Are you using prescribed birth control medication? ....

Do you anticipate becoming pregnant in the near future? .... No Yes

Dental History

Name of Previous Dentist: ______________________________

Date and reason for your last dental visit: ______________________________

Were x-rays taken? .... No Yes

What is your immediate dental concern? ....

DENTAL TREATMENT DESIRED (circle):

Exam   Professional Dental Cleaning   Cosmetic Dentistry   Cavities Restored   Complete Dentures

Missing Teeth Replaced   Teeth Extracted   Orthodontics   Pain Relief

Other ______________________________

Circle

Are you nervous or concerned about having dental work? .... No Yes

Have you ever had an unfavorable experience with dentistry? .... No Yes

Have you ever had complications or illness following dental treatment? .... No Yes

Do you avoid brushing any part of your mouth? .... No Yes

Do your gums bleed when brushing or flossing? .... No Yes

Are any of your teeth sensitive to temperature extremes, biting pressure or sweets? .... No Yes

Do you grind or clench your teeth while sleeping or under stress? .... No Yes

Do you have frequent headaches? .... No Yes

Do you have difficulty opening your mouth? .... No Yes

Have you had orthodontic treatment (braces, retainers)? .... No Yes

Have you ever been treated for periodontal disease (gum disease, pyorrhea, or trench mouth)? .... No Yes

Has a dentist or hygienist shown you how to clean your teeth? .... No Yes

PLEASE CHECK ANY ITEM(S) BELOW THAT YOU USE OFTEN IN MOUTH CARE OR HAVE BEEN SHOWN HOW TO USE:

Hand toothbrush____   Electric toothbrush____   Proxabrush____   Waterpick____   Dental floss____

Gum stimulators, toothpicks____   Mouthwash____   Tongue cleaner____

How often do you brush? ______________   How often do you floss? ______________

AUTHORIZATION

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health, or if any of my medications change, I will inform Dr. Mills or his staff at my next appointment WITHOUT FAIL. I hereby authorize Dr. Mills and/or his hygienist(s) to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. Dr. Mills reserves the right to perform credit reports on any patient.

______________________________   ______________

Signature of Patient, Parent or Guardian   *Date*