(702) 648-2564

Welcome to our Practice

Patient_________________________________Date___________________
Home Address_______________________City_________Zip Code_______
Sex__________Age________DOB_____________Phone # _____________
Referred By______________Dentist________________SS#_____________

Employer_______________________________Group#________________
Address__________________________City____Zip Code_______________
Insured____________________________DOB_________SS#____________
Insurance Co_____________________________Phone #________________
Ins. Address ____

*Email address:____

Emergency Contact :
Name____________________________Relationship__________________
Phone # ___________________________Cell # ______________________

Dental History

Date of last dental cleaning?_______________________

Please mark “Yes or “No” to indicate if you have or had any of the following:

Bad Breath Y___N____
Bad taste Y___N____
Bleeding Gums Y___N____
Blisters on Lips or mouth Y___N____
Burning sensation on tongue Y___N____
Chew on side of mouth Y___N____
Cigarette, pipe or cigar smoking Y___N____
Clicking or popping jaw Y___N____
Dry mouth Y___N____
Fingernail Biting Y___N____
Food collection between teeth Y___N____
Grinding teeth Y___N____
Gums swollen or tender Y___N____

Jaw Pain Y ____N___
Mouth Breather Y___N___
Sensitive to cold/hot Y___N___

How often do you floss? _____

How often do you brush? ____

Medical History

Please mark “Yes “ or “No” if you have or had any of the following:

AIDS Y___N____
Anemia Y___N____
Angina/Chest Pain Y____N____
Artificial Heart Valve Y____N____
Artificial Joint Y____N____
Asthma Y____N____
Bleeding abnormally
w/extractions or surgery Y____N____
Blood Disease Y____N____
Blood Transfusion Y____N____
Cancer Y____N____
Chemical Dependency Y____N____
Circulatory Problem Y____N____
Cirrhosis Y____N____
Congenital Heart Lesion Y____N____
Cortisone Treatments Y____N____
Diabetes Y____N____
Dialysis Y____N____
Drug Use Y____N____

Emphysema Y_____N___
Epilepsy/Seizure Y_____N___
Fainting/Dizziness Y ___N_____
Headaches Y____N____
Heart Murmur Y____N____
Heart Problem Y____N____
Hemophilia Y____N____
Hepatitis Type____ Y____N____
Herpes Y____N____
High Blood Pressure Y____N____
HIV+ Y____N____
Jaundice Y____N____
Jaw Pain Y____N____
Kidney Disease Y_____N___
Leukemia Y____N____
Liver Disease Y____N____
Low Blood Pressure Y____N____
Mitral Valve Prolapse Y____N____
Nervous Problem Y____N____

Prosthetic Replacement Y_____N____
Radiation Treatment Y_____N____
Respiratory Treatment Y_____N____
Rheumatic Fever Y_____N_____
Scarlet Fever Y_____N_____

Women

Are you pregnant? Y_______N_______

Medications

List medication you are currently taking ____

Pharmacy's Name ____

Pharmacy's Number ____

Any other medical conditions?____

____

Allergies

List any or all allergies ____

Nickel Y______N________

Other Drugs/Substances/Material____

****Do you or have you ever taken prophylaxis (antibiotics) prior to treatment of any kind? If yes, please list and notify the front desk/Doctor** Y__________N________**

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any medical changes, etc.

____ ____________________________

Signature Date