



6592 N. Decatur Blvd. Suite 160  
Las Vegas, NV 89131  
(702) 648-2564

## Welcome to our Practice

Patient \_\_\_\_\_ Date \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip  
Code \_\_\_\_\_  
Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Phone # \_\_\_\_\_  
Referred  
By \_\_\_\_\_ Dentist \_\_\_\_\_ SS# \_\_\_\_\_

Mother's  
Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip  
Code \_\_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_  
Employer \_\_\_\_\_ Phone # \_\_\_\_\_  
Insurance Co \_\_\_\_\_ Phone  
# \_\_\_\_\_  
Ins.  
Address \_\_\_\_\_

\*Email  
address: \_\_\_\_\_

Father's Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip  
Code \_\_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_  
Employer \_\_\_\_\_ Phone # \_\_\_\_\_  
Insurance Co \_\_\_\_\_ Phone  
# \_\_\_\_\_

Ins.

Address \_\_\_\_\_

\*Email

address: \_\_\_\_\_

Emergency Contact (Other than Parents)

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__	Jaw Pain	Y__N__
Bad taste	Y__N__	Mouth Breather	Y__N__
Bleeding Gums	Y__N__	Sensitive to cold/hot	Y__N__
Blisters on Lips or mouth	Y__N__	How often do you floss? _____	
Burning sensation on tongue	Y__N__	How often do you brush? _____	
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__		

## Medical History

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

AIDS	Y__N__	Emphysema	Y__N__
Anemia	Y__N__	Epilepsy/Seizure	Y__N__
Angina/Chest Pain	Y__N__	Fainting/Dizziness	Y__N__
Artificial Heart Valve	Y__N__	Headaches	Y__N__
Artificial Joint	Y__N__	Heart Murmur	Y__N__
Asthma	Y__N__	Heart Problem	Y__N__
Bleeding abnormally		Hemophilia	Y__N__
w/extractions or surgery	Y__N__	Hepatitis Type _____	Y__N__
Blood Disease	Y__N__	Herpes	Y__N__
Blood Transfusion	Y__N__	High Blood Pressure	Y__N__
Cancer	Y__N__	HIV+	Y__N__
Chemical Dependency	Y__N__	Jaundice	Y__N__
Circulatory Problem	Y__N__	Jaw Pain	Y__N__
Cirrhosis	Y__N__	Kidney Disease	Y__N__
Congenital Heart Lesion	Y__N__	Leukemia	Y__N__
Cortisone Treatments	Y__N__	Liver Disease	Y__N__
Diabetes	Y__N__	Low Blood Pressure	Y__N__
Dialysis	Y__N__	Mitral Valve Prolapse	Y__N__
Drug Use	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