Welcome to True Dental! We appreciate the confidence you place with us to provide your dental services.
To assist us in serving you, please complete the following form.
The information provided on this form is important for us to provide you with proper dental treatment and for your safety.
If there have been any changes to your health, or if you have any questions, please let us know. Thank you.

Patient Name:_____ Date of Birth:_____ Sex: M / F Age:_____
Home Address:_____ City:_____ State:_____ Zip:_____
Cell Phone Number:_____ E-Mail:_____
Home Phone Number: _____ Employer: _____
Emergency Contact:_____ Relationship:_____ Phone #:_____

Primary Dental Insurance:_____ Group #:_____
Secondary Dental Insurance:_____ Group #:_____
Subscriber's Name:_____ Date of Birth:_____ SSN:_____

Primary Care Physician:_____ Date of Last Medical Visit:_____
Phone Number: _____
Name of Previous Dentist:_____ Date of Last Dental Visit:_____
Phone Number: _____
How did you hear about us?:
□ Mailer □ Street Signage
□ Online (Website, Facebook, Google)
□ Referal _____ Please let us know :) We love to show our gratitude with small gifts

DENTAL HEALTH HISTORY

	Y	N		Y	N
Are you apprehensive about dental visit?	□	□	Do you have or have you had sores or ulcers in your mouth?	□	□
Have you had problems with previous dental treatment?	□	□	Is your mouth dry?	□	□
Do you gag easily?	□	□	Do you notice noise or discomfort when you open/close?	□	□
How often do you brush your teeth? _____			Do you clench or grind your teeth frequently?	□	□
How often do you floss your teeth? _____			Do you notice any headaches upon waking up?	□	□
Do your gums feel swollen, tender or bleed easily?	□	□	Do you have temporomandibular (jaw) disorder (TMD)?	□	□
Do have history of using any tobacco products?	□	□	Have you had any serious trauma to your head or mouth?	□	□
Does food or floss catch between your teeth?	□	□	Have you had any orthodontic (braces)treatment ?	□	□
Do you maily drink bottled or filtered water (Please circle)?			Have you had any periodontal (gum) treatment?	□	□
Are any of your teeth sensitive to:			Is there any concerns or questions about your teeth today?	□	□
Cold or hot temperature	□	□	If so, please describe:		
Sweets	□	□	_____		
Pressure	□	□	How do you feel about your smile?		
Are you currently experiencing dental pain or discomfort?	□	□	_____		

PLEASE COMPLETE REVERSE SIDE

MEDICAL HEALTH HISTORY

	Y	N
Do you wear contact lenses?	☐	☐
Cardiovascular disease	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Congestive heart failure	☐	☐
Chest pain upon exertion	☐	☐
Heart attack or stroke	☐	☐
Heart murmur	☐	☐
Low or high blood pressure	☐	☐
Other congenital heart defects	☐	☐
Mitral valve prolapse	☐	☐
Pacemaker	☐	☐
Blood thinner (ie. aspirin, plavix, warfarin)	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
Blood transfusion Date:	☐	☐
Hemophilia	☐	☐
AIDS or HIV infection	☐	☐
Sexually transmitted disease	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Sinus trouble	☐	☐
Tuberculosis	☐	☐
Diabetes Type I or II Most recent A1c: _____	☐	☐

	Y	N
Arthritis	☐	☐
Systemic lupus erthematosus	☐	☐
Asthma	☐	☐
If so, Last attack? _____	☐	☐
Gastrointestinal disease	☐	☐
G.E.R.D.	☐	☐
Persistant heartburn	☐	☐
Thyroid problems	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Epilepsy	☐	☐
Fainting spells or seizures	☐	☐
Mental disorders If so, Specify: _____	☐	☐
Kidney problems	☐	☐
Severe headaches/migraines	☐	☐
Severe or rapid weight loss	☐	☐
Excessive urination	☐	☐
Do you use controlled substances (drugs)?	☐	☐
Do you use tobacco?	☐	☐
If so, How long? _____ How much? _____		
Do you drink alcoholic beverages?	☐	☐
If so, How much in a week? _____	☐	☐
Have you been diagnosed with osteoporosis?	☐	☐
Are you taking or scheduled to take alendronate (Fosamax) or risedronate (Actonel)?	☐	☐
Were you treated or are you scheduled to begin treatment with the IV bisphosphonates (Aredia or Zometa)?	☐	☐

ALLERGIES - To all YES reponses, please specify type of reaction		
Local anesthethcis	☐	☐
Latex (rubber)	☐	☐
Penicillin or other antibiotics	☐	☐
Sedative, barbituates, or sleeping pills	☐	☐
Sulfa drugs	☐	☐
Codeine or other narcotics	☐	☐
Metals	☐	☐
Food	☐	☐
Hay fever/seasonal	☐	☐
Other: _____		

WOMEN ONLY Are you:		
Pregnant? If so, Numbe of weeks: _____	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐
Nursing?	☐	☐

For **ANTIBIOTIC PROPHYLAXIS**		
Have you had any total joint replacement?	☐	☐
Date:		
Artificial heart valve	☐	☐
Previous infective endocarditis	☐	☐
Congenital heart disease (CHD)	☐	☐
Has a dentist or physician recommended that you take antibiotics prior to dental treatment?	☐	☐

Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐
If so, please specify: _____		

Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐
If so, please specify: _____		

I certify that I have read and understand the above and that the information given on this form is accurate. My quesions, if any, about inquiries set forth above have been answered to my satisfaction.

Sign of Patient/Legal Guardian: Date: