Date _____ S.S.# _____

Patient Name: _____ **Birthdate:** _____ Marital Status _____

Address: _____ City/State _____ Zip _____ Telephone _____

Place of Employment _____ Telephone _____

Place of Employment Address _____ Cell/Beeper # _____

Spouse/Responsible Party _____ Email Address: _____

Place of Employment _____ Telephone _____

Place of Employment Address _____

Your Dentist: _____ Time with Him/Her: Years _____

Your Physician: _____

Referred by: _____

DENTAL/MEDICAL HISTORY

Are you in pain now? _____

Last dental visit _____ What services _____ Last cleaning _____

Have you ever had Periodontal Treatment? _____ When? _____ By Whom? _____

Do gums bleed or swell? _____ Mouth Ulcers? _____

Are teeth sensitive? _____

Do you have dentures, partials, or bridges? _____

How often do you brush? _____ Floss? _____ Use water spray? _____

Do you clench or grind your teeth? _____

Have you had TMJ treatment and/or pain? _____

Are you nervous about dental treatment? _____

Comments: _____

Date of last physical exam _____ Physician doing exam _____

1. Presently under physician's care? _____
2. Have you had any recent illnesses? _____
3. Have dental anesthetics caused any problems? _____
   _____
4. Are you allergic to any medications? _____
5. Do you take aspirin, blood-thinners or have abnormal bleeding problems? _____
6. Have you had convulsions? _____ Epilepsy? _____
7. Do you have any of the following viruses?
   Hepatitis A _____ When? _____
   Hepatitis B _____ Carrier _____
   Hepatitis C _____ AIDS (HIV) _____ ❑ Pos. ❑ Neg.
8. Have you had rheumatic fever? _____
9. Heart defects, valves? _____
10. Heart disease? _____
11. Heart surgery? When? _____
12. Lung diseases, T.B.? _____
13. Liver diseases? _____
14. Thyroid problems? _____
15. Do you have high or low blood pressure? Yes ❑ No ❑
    Medication _____
16. Do you have diabetes? _____ Medication _____
17. Do you have ulcers? _____
18. Have you had kidney disease? _____
19. Have you had x-ray therapy to the head or neck region?
    _____
20. Have you had joint replacement? _____
21. Do you smoke? _____
22. Are you pregnant? _____
23. Are you or have you been chemically dependent? _____
24. Have you been or are you now under psychiatric care?
    _____
25. List all other medications: _____
    _____

Release: I authorize the release of any medical or dental information to Dr. Westmoreland that will be necessary and beneficial in my treatment. I also authorize Dr. Westmorelad to discuss my treatment with other physicians and dentists when this is necessary and in my best interest.

Signature: _____