PATIENT INFORMATION (Confidential)

Patient Name: _____ **Date of Birth:** _____
First Last

Parent / Guardian if patient is a minor: _____ **Date of Birth:** _____

Address:

_____
Street City State Zip Code

Cell Phone: _____ **Home Phone:** _____ **E-Mail:** _____

Employer _____ Work Phone _____ Social Security Number _____

In case of an emergency please contact: _____ _____ _____
Name Phone Number Relationship to You

How did you find our office: ☐ Online, ☐ My Insurance, ☐ Friend, Family Member or Co-worker (whom may we thank for the referral?): _____ ☐ Sign out front / have driven bye, or ☐ other (please list): _____

PATIENT MEDICAL HISTORY

Are you taking any medications? NO ☐ YES ☐ (Please List) _____

Are you taking any vitamins or herbal supplements? NO ☐ YES ☐ (Please List) _____

Are you **allergic or sensitive to any medications**? NO ☐ YES ☐ (Please List) _____

Have you ever been told to pre-medicate with antibiotics before dental appointments? NO ☐ YES ☐ (List Condition) _____

Do you smoke/use tobacco? NO ☐ YES ☐ Do you drink pop/coffee? NO ☐ YES ☐ Women: Are you pregnant? NO ☐ YES ☐

Have you ever been diagnosed with any of the following? (Please check each box individually)

Allergies	NO ☐ YES ☐	Epilepsy/Seizures	NO ☐ YES ☐	Tuberculosis	NO ☐ YES ☐
Asthma	NO ☐ YES ☐	Radiation Therapy	NO ☐ YES ☐	Heart Murmur	NO ☐ YES ☐
Sinus Trouble	NO ☐ YES ☐	Rheumatic Fever	NO ☐ YES ☐	Heart Surgery	NO ☐ YES ☐
Diabetes	NO ☐ YES ☐	HIV/AIDS	NO ☐ YES ☐	Hepatitis	NO ☐ YES ☐ (What Type) _____
Stroke	NO ☐ YES ☐	Chemical Dependency	NO ☐ YES ☐	Mitral Valve Prolapse	NO ☐ YES ☐
High Blood Pressure	NO ☐ YES ☐	Depression	NO ☐ YES ☐	Joint Replacement	NO ☐ YES ☐ _____

Have you been diagnosed / treated for any other serious illnesses or operations not listed above? NO ☐ YES ☐ (Please list): _____

PATIENT DENTAL HISTORY

Former Dentist: _____ Last Dental Visit: _____ When where your last x-rays taken: _____

Are you nervous about having dental treatment? NO ☐ YES ☐ Have you ever had a bad experience at a dental office? NO ☐ YES ☐

How often do you brush your teeth? _____ Have you had previous periodontal treatment (gum disease)? NO ☐ YES ☐

Do you ever have jaw soreness/discomfort related to TMJ? NO ☐ YES ☐ Would you like whiter teeth? NO ☐ YES ☐

Is there anything you dislike about your teeth/smile or do you have any specific concerns in regards to your teeth/smile?

Consent:

I have reviewed the information on this form and it is accurate to the best of my knowledge. I authorize Dr. Olson to use my provided information to determine any appropriate dental needs and give him permission to do any treatment deemed necessary.

Patient Signature: _____ **Date:** _____

Parent / Guardian Signature: _____ **Date:** _____