



Today's Date: _____ Email Address: _____
(Used for appointment reminders and surveys only)

Prefix: ___ Mr. ___ Mrs. ___ Ms. ___ Dr.

Name: _____ Name I prefer to be called: _____
Last First MI

Birthdate: ___/___/___ Age: ___ Social Security # _____

Single ___ Married ___ Divorced ___ Separated ___ Widowed ___

Home Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Home Phone _____ Cell _____ Work _____

Whom may we thank for referring you? _____

How did you hear about us? ___ Web site ___ Mailer ___ Insurance

Other family members seen at Sandalwood: _____

Employer: _____ Occupation: _____

Emergency Contact Information

His/Her Name: _____ Relationship to you: _____

Home Phone _____ Cell _____ Work _____

Insurance Information

Insurance Co. Name: _____ Phone # _____ Group # _____

Insured's Name: _____ Insured's Social Security # _____

Insured's Address: _____
Street City State Zip

Insured's Birthdate: ___/___/___ Relationship: _____ Insured's Employer: _____

Health History

What is your goal for today's visit? _____ Date of last dental visit _____

How would you describe the condition of your teeth and gums? ___ Good ___ Fair ___ Poor

How often do you brush your teeth? _____ How often do you floss? _____

Are you currently experiencing any discomfort with your teeth or gums? ___ No ___ Yes

If yes, please explain _____

So that we may provide you with a custom treatment plan designed to meet your interests, check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Do your gums bleed when you brush or floss? | <input type="checkbox"/> Are you interested in Invisalign? |
| <input type="checkbox"/> Do you grind your teeth at night or during the day? | <input type="checkbox"/> Are you interested in implants to replace teeth? |
| <input type="checkbox"/> Do you snore or suffer from sleep apnea? | <input type="checkbox"/> Are you interested in whitening your teeth? |
| <input type="checkbox"/> Do you have discomfort in your jaw or headaches? | <input type="checkbox"/> Are you interested in sedation dentistry? |
| <input type="checkbox"/> Do you have sensitive teeth? | <input type="checkbox"/> Are you interested in veneers or Lumineers? |

Have you been hospitalized in the past 5 years? Reason _____

Are you currently under the care of a physician? For which condition? _____

Primary physician's name _____ Number _____

Specialist(s) name _____ Number _____

For the following conditions, please check all that apply. Your answers are for our records only and are confidential.

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Respiratory illness | <input type="checkbox"/> Slow healing mouth sores |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Abnormal heart condition | <input type="checkbox"/> Other infections |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Recurrent illness |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart attack or disease | <input type="checkbox"/> Joint replacement |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Psychosis, psychiatric care | <input type="checkbox"/> Abnormal bleeding |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sore / enlarged lymph nodes | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> HIV positive | <input type="checkbox"/> Cancer / previous biopsy | <input type="checkbox"/> Latex sensitivity |
| <input type="checkbox"/> Osteoporosis | Other condition _____ | |

Are you required to pre-medicate prior to your dental appointment? ___ Yes ___ No

Have you ever been diagnosed with abnormal blood pressure? ___ Yes ___ No

What is your normal blood pressure? ___ / ___

Women, are you ___ Pregnant? ___ Planning on becoming pregnant? ___ Using birth control medication?

Are you allergic to or have you had an adverse reaction to:

- Local anesthesia? Penicillin or other antibiotics? Aspirin? Codeine or other pain reliever?
 Sulfa drugs? Jewelry / Metal?

Are you a smoker? If so, how much do you smoke? _____

Please list any medications that you currently take including supplements. If more than four, please provide a list.

1. _____ 2. _____ 3. _____ 4. _____

I affirm that the information I have given here is correct to the best of my knowledge and that it is my responsibility to inform Sandalwood Dental of any changes in my medical status. I understand that I could put my health at risk by failing to disclose my full health history.

Signature: _____ Date: _____