



We are pleased to welcome you into our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_
Last Name First Name Middle Initial
Address \_\_\_\_\_ How long at this address? \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Home Phone \_\_\_\_\_
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_
Sex [ ] M [ ] F Age \_\_\_\_\_ Birth date \_\_\_\_\_ [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced
Employer \_\_\_\_\_ Number of Years \_\_\_\_\_ Occupation \_\_\_\_\_
Business Phone \_\_\_\_\_
Whom may we thank for referring you? \_\_\_\_\_
Notify in case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

Primary Insurance

Person Responsible for Account \_\_\_\_\_
Last Name First Name Middle Initial
Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_
Address (if different from patient) \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone Number \_\_\_\_\_
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_
Employer \_\_\_\_\_ Occupation \_\_\_\_\_
Business Phone \_\_\_\_\_
Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_
Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Additional Insurance

Is patient covered by additional insurance? [ ] Yes [ ] No
Subscriber Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_
Address (if different from patient) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Home Phone \_\_\_\_\_
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_
Subscriber's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_
Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_
Insurance Email \_\_\_\_\_
Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

I understand that it is my responsibility to contact my dental insurance company to determine what dental insurance benefits I have available. I understand that as a courtesy Harris and Reynolds Family Dental will help me file my claims for dental work performed at their office. Signature (Parent/Guardian Signature, if minor) \_\_\_\_\_



We are pleased to welcome you into our practice. So that we may provide you with the best possible care, please complete this dental history form. All information is completely confidential.

Patient Name: \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Last Full Mouth X-rays \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

What other dental aids do you use? (Interplak, toothpick, etc.) \_\_\_\_\_

Do you have any dental problems now? Yes No

If yes, please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or

any other oral lesions? Yes No

**Do your gums bleed or hurt?** Yes No

Have your parents experienced gum disease or

tooth loss? Yes No

Have you noticed any loose teeth or change in your

bite? Yes No

Does food tend to become caught in between your

teeth? Yes No

If yes, where? \_\_\_\_\_

**Do you:**

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? Yes No

(pencils, pipe, pins, nails, fingernails, etc.)

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Snore or have any other sleep disorders? Yes No

Smoke/chew tobacco or use other tobacco

products? Yes No

**Have you ever had:**

Orthodontic treatment? Yes No

Oral Surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or your bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause \_\_\_\_\_

**Have you experienced:**

Clicking or popping of the jaw? Yes No

Pain? ( joint, ear, side of the face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth Yes No

Headaches, neckaches or shoulder aches?

Sore muscles (neck, shoulders)?

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your

life? Yes No

Do you feel nervous about having dental treatment?

If so, what is your biggest concern? \_\_\_\_\_ Yes No

Have your ever had an upsetting dental

experience? Yes No

If yes, please describe \_\_\_\_\_

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe \_\_\_\_\_



Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient Name: \_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_

Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No
Are you on a special diet?  Yes  No
Do you use tobacco?  Yes  No
Do you use controlled substances?  Yes  No

Women: Are you

Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics
 Other, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

AIDS/HIV Positive  Yes  No Cortisone Medications  Yes  No Hemophilia  Yes  No Renal Dialysis  Yes  No
Alzheimer's Disease  Yes  No Diabetes  Yes  No Hepatitis A  Yes  No Rheumatic Fever  Yes  No
Anaphylaxis  Yes  No Drug Addiction  Yes  No Hepatitis B or C  Yes  No Rheumatism  Yes  No
Anemia  Yes  No Easily Winded  Yes  No Herpes  Yes  No Scarlet Fever  Yes  No
Angina  Yes  No Emphysema  Yes  No High Blood Pressure  Yes  No Shingles  Yes  No
Arthritis/Gout  Yes  No Epilepsy or Seizures  Yes  No Hives or Rash  Yes  No Sickle Cell Disease  Yes  No
Artificial Heart Valve  Yes  No Excessive Bleeding  Yes  No Hypoglycemia  Yes  No Sinus Trouble  Yes  No
Artificial Joint  Yes  No Excessive Thirst  Yes  No Irregular Heartbeat  Yes  No Spina Bifida  Yes  No
Asthma  Yes  No Fainting Spells/Dizziness  Yes  No Kidney Problems  Yes  No Stomach/Intestinal Disease  Yes  No
Blood Disease  Yes  No Frequent Cough  Yes  No Leukemia  Yes  No Stroke  Yes  No
Blood Transfusion  Yes  No Frequent Diarrhea  Yes  No Liver Disease  Yes  No Swelling of Limbs  Yes  No
Breathing Problem  Yes  No Frequent Headaches  Yes  No Low Blood Pressure  Yes  No Thyroid Disease  Yes  No
Bruise Easily  Yes  No Genital Herpes  Yes  No Lung Disease  Yes  No Tonsillitis  Yes  No
Cancer  Yes  No Glaucoma  Yes  No Mitral Valve Prolapse  Yes  No Tuberculosis  Yes  No
Chemotherapy  Yes  No Hay Fever  Yes  No Pain in Jaw Joints  Yes  No Tumors or Growths  Yes  No
Chest Pains  Yes  No Heart Attack/Failure  Yes  No Parathyroid Disease  Yes  No Ulcers  Yes  No
Cold Sores/Fever Blisters  Yes  No Heart Murmur  Yes  No Psychiatric Care  Yes  No Venereal Disease  Yes  No
Congenital Heart Disorder  Yes  No Heart Pace Maker  Yes  No Radiation Treatments  Yes  No Yellow Jaundice  Yes  No
Convulsions  Yes  No Heart Trouble/Disease  Yes  No Recent Weight Loss  Yes  No  Yes  No

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my ( or patient's ) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_