PATIENT INFORMATION

PATIENT'S NAME: _____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY #: _____

STREET ADDRESS: _____

TOWN: _____ STATE: _____ ZIP: _____

PHONE #S: (H): _____ (W): _____ (C): _____

EMAIL: _____

RESPONSIBLE PARTY & RELATIONSHIP: *if minor*_____

If college student, name of school: _____

Whom may we thank for referring you to our office? _____

EMERGENCY CONTACT *name & phone*: _____

PREVIOUS DENTIST & PHONE #: _____

DATE OF LAST VISIT & REASON FOR VISIT: _____

MEDICAL INFORMATION

1. Are you experiencing any discomfort? …… YES NO
2. Are you in good health? ..... YES NO
3. Has there been a change in your general health within the past year? ..... YES NO
4. Are you under the care of a physician? …… YES NO
   If so, what condition is being treated? _____
   Physician's name: _____ Phone#:_____
5. Have you been hospitalized or had a serious operation or illness within the last 5 yrs? ……. YES NO
6. Do you have or have you had any of the following diseases or problems? ……. YES NO

(Circle all that apply)

Angina	Scarlet Fever	Pain in Jaw Joints (TMJ)
Heart Disease / Heart Attack	Fainting or Dizzy Spells	Psychiatric Treatment
Heart Failure	Emphysema	Epilepsy or Seizures
Heart Surgery	Tuberculosis (TB)	Chemotherapy (Cancer, Leukemia)
Stroke	Asthma	X-ray or Cobalt Treatment
Heart Pacemaker-Date _____	Allergies or Hives	Diabetes
Heart Murmur	Hepatitis A (Infectious)	Thyroid Disease
High Blood Pressure	Hepatitis B (Serum)	Glaucoma / Cataract
Artificial Heart Value	Hepatitis C	Arthritis
Mitral Valve Prolapse (MVP)	Liver Disease or Jaundice	Rheumatism
Congenital Heart Lesions	Kidney Trouble	STD / HPV / VD
Artificial Joint / Replacement	Ulcers	AIDS / HIV
Rheumatic Fever	Sinus Trouble	Cold Sores (Herpes)

7. Have you ever been told to premedicate prior to dental appointments? ……. YES NO
8. Are you taking any drugs or medication? …… YES NO
   If so, list _____

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9. Are you allergic or have you reacted adversely to any drugs or medicines? …….. YES NO

(Circle all that apply)

Alcohol	Articaine	Local Anesthetic	Percodan
Aspirin	Codeine	Lidocaine	Septocaine
Amoxicillin	Epinephrine	Novacaine	Tetracycline
Clindamycin	Erythromycin	Penicillin	Valium

Other: _____

10. Have you had any serious trouble associated with previous extractions, surgery, or trauma? YES NO
    If so, explain _____
11. Do you have a disease, condition, or problem not listed that you think I should know about? YES NO
    If so, explain _____
12. **FOR WOMEN ONLY**: Are you pregnant? ..... YES NO If yes, what month? ____
    …..Nursing? ….. YES NO

AESTHETIC PROFILE

Please answer the following questions so that we may get to know you better.

Are you happy with the appearance of your teeth?	YES	NO
Would you like your teeth to look whiter?	YES	NO
Would you like to see your smile look different?	YES	NO
Do you like the shape of your teeth?	YES	NO
Do you have discolored teeth that bother you?	YES	NO
Are you here for a specific reason?	YES	NO

Please explain: _____

Please check off the things that would keep you from pursuing your dental treatment:
Cost ___ Fear ___ Lack of time ___ Lack of importance ___ All ___

I understand and authorize Dr. Edward Johnson and his associates to take all diagnostic materials necessary to make a final diagnosis of dental treatment. Diagnostic materials may include intra-oral pictures, digital radiographs, diagnostic models, photographs, and slides. This material may be used for education, lectures, articles, communications, promotions, and/or publications. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, which may be indicated in connection with (Name of patient) _____ and further, authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

PATIENT SIGNATURE: _____ DATE: _____

PARENT or RESPONSIBLE PARTY SIGNATURE: _____

WITNESS: _____