



**Guest Information**

Date \_\_\_\_\_

Name \_\_\_\_\_ M/F Birth date \_\_\_\_\_ SS # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Business Phone \_\_\_\_\_ Email address \_\_\_\_\_

*Please circle primary contact above (for making and confirming appointments.)*

Spouse/Parent/Guardian Name \_\_\_\_\_

Responsible Party Driver's License # \_\_\_\_\_

Guest/Parent Employer \_\_\_\_\_ Address \_\_\_\_\_

Spouse Employer \_\_\_\_\_ Address \_\_\_\_\_

Emergency Contact Name and Number \_\_\_\_\_ Relationship \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Previous Dentist \_\_\_\_\_ Phone \_\_\_\_\_ Last Visit \_\_\_\_\_

**Insurance Information**

Dental Insurance Program \_\_\_\_\_ Subscriber SS # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber Address (if different from above) \_\_\_\_\_

Subscriber Employer \_\_\_\_\_ Subscriber Birth date \_\_\_\_\_

Secondary Insurance Program \_\_\_\_\_ Subscriber SS # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber Employer \_\_\_\_\_ Subscriber Birth date \_\_\_\_\_

# Medical History

Physician \_\_\_\_\_ Office phone \_\_\_\_\_ Last Visit \_\_\_\_\_

Have you had a severe illness or been hospitalized in the last five years? **Y / N** Date \_\_\_\_\_  
Reason: \_\_\_\_\_

Have you ever taken: Phen-Fen/Redux/Pondimin? **Y / N** Bisphosphonates (i.e. Fosamax)? **Y / N**

Have you been told you need pre-medication for dental visits? **Y / N** Reason: \_\_\_\_\_  
Physician \_\_\_\_\_ Phone \_\_\_\_\_

Have you ever had an adverse reaction during or in conjunction with a medical or dental procedure?  
**Y / N** \_\_\_\_\_

Please list all allergies to medications, local anesthetics, metals, latex, food, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all medications you are currently taking:

<i>Medication</i>	<i>Dosage</i>	<i>Reason</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate which of the following you have or have had:

- |   |   |
|---|---|
| <input type="checkbox"/> Heart Disease                      | <input type="checkbox"/> Hepatitis (type _____)         |
| <input type="checkbox"/> Angina                             | <input type="checkbox"/> Lung Disease/Tuberculosis      |
| <input type="checkbox"/> Mitral Valve Prolapse              | <input type="checkbox"/> Arthritis                      |
| <input type="checkbox"/> Pacemaker (Yr _____)<br>Type _____ | <input type="checkbox"/> Seizures/Epilepsy              |
| <input type="checkbox"/> Artificial Heart Valve (yr _____)  | <input type="checkbox"/> Diabetes                       |
| <input type="checkbox"/> Heart Murmur                       | <input type="checkbox"/> Asthma/Respiratory Problems    |
| <input type="checkbox"/> Excessive Bleeding                 | <input type="checkbox"/> Rheumatic Fever (yr _____)     |
| <input type="checkbox"/> High/Low Blood Pressure            | <input type="checkbox"/> Cancer (type) _____ (yr _____) |
| <input type="checkbox"/> Stroke (yr _____)                  | <input type="checkbox"/> Radiation Therapy (yr _____)   |
| <input type="checkbox"/> Sinus Problems                     | <input type="checkbox"/> Chemotherapy (yr _____)        |
| <input type="checkbox"/> Frequent Cold Sores                | <input type="checkbox"/> Tobacco usage                  |
| <input type="checkbox"/> Aids or HIV Infection              | <input type="checkbox"/> Thyroid Problems               |
| <input type="checkbox"/> Sexually Transmitted Disease       | <input type="checkbox"/> Prosthetic Joints (yr _____)   |
|   | <input type="checkbox"/> Glaucoma                       |

Other \_\_\_\_\_

Please list surgeon and phone number for all medical procedures above:

\_\_\_\_\_  
\_\_\_\_\_

**Women Only:**

Are you or might you be pregnant? Y / N Due Date: \_\_\_\_\_

Are you nursing? Y / N Are you taking any contraceptives/hormones? Y / N

**Dental Health**

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

Do your gums bleed? Y / N \_\_\_\_\_

Do you notice bad breath? Y / N \_\_\_\_\_

Are you a mouth breather? Y / N \_\_\_\_\_

Does food or dental floss get stuck between your teeth? Y / N Where? \_\_\_\_\_

Do you have frequent headaches or neck aches? Y / N \_\_\_\_\_

Location \_\_\_\_\_

Typical time of day \_\_\_\_\_

Frequency \_\_\_\_\_

Usual duration \_\_\_\_\_

Have you ever had any head, neck, or jaw injuries? Y / N \_\_\_\_\_

Do you clench or grind your teeth? Y / N \_\_\_\_\_

Does your jaw sometimes feel tired? Y / N Morning or evening?

Does your jaw get stuck (open or closed)? Y / N

Do you hear noise, clicking, or popping in your jaw joints? Y / N

Do you have any problems chewing food? Y / N

Do you frequently bite your lips, tongue, or cheek when chewing? Y / N

Are your teeth sensitive to temperature, sweet, sour, or chewing? Y / N

Do your teeth feel loose? Y / N

Do your teeth seem to be drifting? Y / N

How would you rate your smile? 1 2 3 4 5 6 7 8 9 10 Would you like to change anything?

Are there any other concerns regarding your teeth you would like to discuss with Dr. Schoepflin?

**Authorization Signature** \_\_\_\_\_

Guest and Medical History review Date \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_

Date \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_