



John B Chrispens, DDS

PATIENT INFORMATION

Mr. / Mrs. / Ms. PATIENT: _____ Birth Date: ____ / ____ / ____ Home Phone: (____) _____
 Home Address: _____ Cell Phone: (____) _____
 City: _____ Zip: _____ Email Address: _____
 SS#: _____ - _____ - _____ Driver's License #: _____ Expires: ____ / ____ / ____
 Are you (please circle one of the following): Single Married Divorced Widowed
 Employer: _____ Occupation: _____ Work Phone: (____) _____
 Work Address: _____ City: _____ Zip: _____

Physician: _____ City/State: _____ Physician's Phone: (____) _____
 Dentist: _____ City/State: _____ Dentist's Phone: (____) _____
 Nearest Relative/Friend: _____ Phone: (____) _____
 Whom may we thank for your referral? _____

Spouse's Name: _____ Birth Date: ____ / ____ / ____ SS#: _____ - _____ - _____
 Spouse's Employer: _____ Occupation: _____ Work Phone: (____) _____
 Work Address: _____ City: _____ Zip: _____

Do you have dental insurance? (Please circle "yes" or "no") Yes No
 Primary Subscriber: _____ Secondary Subscriber: _____
 Subscriber's SS#: _____ - _____ - _____ Subscriber's SS#: _____ - _____ - _____
 Policy/Group #: _____ Policy/Group #: _____
 Insurance Company: _____ Insurance Company: _____
 Insurance Address: _____ Insurance Address: _____
 City/State: _____ Zip: _____ City/State: _____ Zip: _____
 Insurance Phone: (____) _____ Insurance Phone: (____) _____

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location: _____ Date of last dental exam: ____ / ____ / ____
 When were your last dental X-Ray's and where were they taken: ____ / ____ / ____
 How often do you brush your teeth? _____ When: AM PM
 Which method do you use: Hand brushing Electric toothbrush Which type is it: soft bristle medium bristle hard bristle
 What other dental products do you use regularly? _____
 Have you ever been informed you have periodontal disease? yes no If yes, when? ____ / ____ / ____
 If yes, by whom? _____
 Have you had previous periodontal treatment? yes no If yes, by whom? _____
 If yes, when and what treatment? ____ / ____ / ____
 What are your Dental/Periodontal concerns: _____
 Do your gums bleed while brushing or flossing? yes no Are your teeth sensitive to hot or cold liquids/foods? yes no
 Are your teeth sensitive to sweet or sour liquids/foods? yes no Do you feel pain to any of your teeth? yes no
 Do you have any sores or lumps in your mouth? yes no Have you had any head, neck or jaw injuries? yes no
 Have you ever experienced any of the following problems in your jaw: Clicking? yes no
 Pain (joint, ear, side of face)? yes no Difficulty in opening or closing? yes no Difficulty in chewing? yes no
 Do you clench or grind your teeth? yes no Do you bite your lips or cheeks frequently? yes no
 Have you ever had any prolonged bleeding following an extraction? yes no
 Have you had orthodontic treatment? yes no If yes, when? ____ / ____ / ____ If yes, by whom? _____
 Do you have dental implants? yes no If yes, when? ____ / ____ / ____ If yes, by whom? _____
 Do you like your smile? yes no How important is it to you to keep your teeth? Extremely Somewhat Unimportant
 Do you have any anxieties about dental treatment? yes no
 Do you practice stress management? yes no If yes, what? _____
 Are you currently in a regular exercise/physical activity program? yes no If yes, what? _____
 Have you used Nitrous Oxide or any other drug for previous dental treatment? yes no

PATIENT MEDICAL HISTORY

How would you describe your present health? (Please circle one) Excellent Good Fair Poor Don't Know

Date of last physical exam: / / Height: " Weight: lbs

Are you currently being treated medically? yes no If yes, please explain: _____

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? yes no

If yes, please explain: _____

Have you ever taken Phen-Fen? yes no

Have you ever taken Redux? yes no

Do you use tobacco products or smoke? yes no If yes, how often? _____

Women only: Are you pregnant or think you may be pregnant? yes no If yes, due date: / /

Are you nursing? yes no

Are you taking oral contraceptives? yes no What: _____

Are you allergic to or have you had any reactions to the following? (Please mark "yes" or "no" for each)

Alcohol	<input type="checkbox"/> yes	<input type="checkbox"/> no	Dental Anesthetics	<input type="checkbox"/> yes	<input type="checkbox"/> no	Penicillin	<input type="checkbox"/> yes	<input type="checkbox"/> no
Aspirin	<input type="checkbox"/> yes	<input type="checkbox"/> no	Erythromycin	<input type="checkbox"/> yes	<input type="checkbox"/> no	Other Antibiotics	<input type="checkbox"/> yes	<input type="checkbox"/> no
Barbiturates/Sedatives	<input type="checkbox"/> yes	<input type="checkbox"/> no	Iodine	<input type="checkbox"/> yes	<input type="checkbox"/> no	Sulfa Drugs	<input type="checkbox"/> yes	<input type="checkbox"/> no
Codeine	<input type="checkbox"/> yes	<input type="checkbox"/> no	Latex	<input type="checkbox"/> yes	<input type="checkbox"/> no	Tetracycline	<input type="checkbox"/> yes	<input type="checkbox"/> no
Demerol	<input type="checkbox"/> yes	<input type="checkbox"/> no	Mint	<input type="checkbox"/> yes	<input type="checkbox"/> no	Valium	<input type="checkbox"/> yes	<input type="checkbox"/> no
Other Drugs	<input type="checkbox"/> yes	<input type="checkbox"/> no	What: _____					

Do you have or have you had any of the following? (Please mark "yes" or "no" for each)

Heart Disease/Surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no						
Heart Attack	<input type="checkbox"/> yes	<input type="checkbox"/> no	Heart Murmur	<input type="checkbox"/> yes	<input type="checkbox"/> no	Cardiac Pacemaker	<input type="checkbox"/> yes	<input type="checkbox"/> no
Chest Pains	<input type="checkbox"/> yes	<input type="checkbox"/> no	Congenital Heart Lesion	<input type="checkbox"/> yes	<input type="checkbox"/> no	Mitral Valve Prolapse	<input type="checkbox"/> yes	<input type="checkbox"/> no
AIDS or HIV	<input type="checkbox"/> yes	<input type="checkbox"/> no	Easily winded	<input type="checkbox"/> yes	<input type="checkbox"/> no	Lung/Respiratory Problems	<input type="checkbox"/> yes	<input type="checkbox"/> no
Anemia	<input type="checkbox"/> yes	<input type="checkbox"/> no	Emphysema	<input type="checkbox"/> yes	<input type="checkbox"/> no	Nervousness/Anxiety	<input type="checkbox"/> yes	<input type="checkbox"/> no
Angina	<input type="checkbox"/> yes	<input type="checkbox"/> no	Epilepsy/Convulsions	<input type="checkbox"/> yes	<input type="checkbox"/> no	Osteoporosis	<input type="checkbox"/> yes	<input type="checkbox"/> no
Arthritis/Rheumatism	<input type="checkbox"/> yes	<input type="checkbox"/> no	Excessive thirst	<input type="checkbox"/> yes	<input type="checkbox"/> no	Psychiatric Care	<input type="checkbox"/> yes	<input type="checkbox"/> no
Asthma/Sinus Problems/Hay Fever	<input type="checkbox"/> yes	<input type="checkbox"/> no	Fainting/Seizures	<input type="checkbox"/> yes	<input type="checkbox"/> no	Recent weight loss/gain	<input type="checkbox"/> yes	<input type="checkbox"/> no
Back problems/surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no	Frequent urination	<input type="checkbox"/> yes	<input type="checkbox"/> no	Recurrent infections	<input type="checkbox"/> yes	<input type="checkbox"/> no
Blood Disease/Disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no	Frequently tired	<input type="checkbox"/> yes	<input type="checkbox"/> no	Rheumatic Fever	<input type="checkbox"/> yes	<input type="checkbox"/> no
Bruise easily	<input type="checkbox"/> yes	<input type="checkbox"/> no	Glaucoma	<input type="checkbox"/> yes	<input type="checkbox"/> no	Rheumatism	<input type="checkbox"/> yes	<input type="checkbox"/> no
Cancer or Tumor	<input type="checkbox"/> yes	<input type="checkbox"/> no	Headaches, frequent/severe	<input type="checkbox"/> yes	<input type="checkbox"/> no	Scarlet Fever	<input type="checkbox"/> yes	<input type="checkbox"/> no
Chemical Dependency	<input type="checkbox"/> yes	<input type="checkbox"/> no	Hemophilia	<input type="checkbox"/> yes	<input type="checkbox"/> no	Sickle Cell Disease	<input type="checkbox"/> yes	<input type="checkbox"/> no
Chemotherapy or Radiation	<input type="checkbox"/> yes	<input type="checkbox"/> no	Hepatitis	<input type="checkbox"/> yes	<input type="checkbox"/> no	Special Diet	<input type="checkbox"/> yes	<input type="checkbox"/> no
Circulatory Problems	<input type="checkbox"/> yes	<input type="checkbox"/> no	Herpes/STD's	<input type="checkbox"/> yes	<input type="checkbox"/> no	Stroke	<input type="checkbox"/> yes	<input type="checkbox"/> no
Cold sores/Fever blisters	<input type="checkbox"/> yes	<input type="checkbox"/> no	High Blood Pressure	<input type="checkbox"/> yes	<input type="checkbox"/> no	Swollen ankles	<input type="checkbox"/> yes	<input type="checkbox"/> no
Colitis	<input type="checkbox"/> yes	<input type="checkbox"/> no	Jaundice	<input type="checkbox"/> yes	<input type="checkbox"/> no	Tension	<input type="checkbox"/> yes	<input type="checkbox"/> no
Contact lenses, do you wear?	<input type="checkbox"/> yes	<input type="checkbox"/> no	Jaw pain	<input type="checkbox"/> yes	<input type="checkbox"/> no	Thyroid problems	<input type="checkbox"/> yes	<input type="checkbox"/> no
Cortisone Treatments	<input type="checkbox"/> yes	<input type="checkbox"/> no	Joint Replacement	<input type="checkbox"/> yes	<input type="checkbox"/> no	Tonsillitis	<input type="checkbox"/> yes	<input type="checkbox"/> no
Cosmetic surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no	Kidney Disease/Disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no	Tuberculosis	<input type="checkbox"/> yes	<input type="checkbox"/> no
Cough, persistent or bloody	<input type="checkbox"/> yes	<input type="checkbox"/> no	Leukemia	<input type="checkbox"/> yes	<input type="checkbox"/> no	Ulcer	<input type="checkbox"/> yes	<input type="checkbox"/> no
Depression	<input type="checkbox"/> yes	<input type="checkbox"/> no	Liver Disease/Disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no			
Diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no	Low Blood Pressure	<input type="checkbox"/> yes	<input type="checkbox"/> no			

I certify that I have read and understand the above questions. The above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to the best of my understanding. I will not hold John B Chrispens, DDS, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form. Further, I understand that changes to my appointments may incur charges of up to 50% of the scheduled treatment fee when not made with at least two business days' notice.

Patient Signature/Responsible Party: _____ Date: / /

(OVER)