Chrispens & Evans 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: / / Cell Phone - _____

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	yes	no	Dental Anesthetics	yes	no	Penicillin	yes	no
Aspirin	yes	no	Erythromycin	yes	no	Other Antibiotics	yes	no
Barbiturates/Sedatives	yes	no	Iodine	yes	no	Sulfa Drugs	yes	no
Codeine	yes	no	Latex	yes	no	Tetracycline	yes	no
Demerol	yes	no	Mint	yes	no	Valium	yes	no
Other Drugs	yes	no	What:					

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

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