ADULT NEW PATIENT FORM

Name: _____Sex:_____Age:_____DOB:_____

Address: _____City:_____St:_____Zip:_____

Phone: #:_____Email_____

Employer: _____Occupation:_____Work#:_____

Marital Status: ____Spouse:_____Phone:_____

Have we treated other members of your family? If so, list names:

_____

**********Medical History**********

Are you in good health? ____Yes ____No
Do you breathe through Mouth? ____, Nose ____, or Both____?
Have your suffered trauma to head/neck? ____ Yes ____No If yes, at what age? ____
Have you been in motor vehicle accident? ____Yes ____No If yes, at what age? ____

Have you had any of these illnesses listed below? **Mark X for No, ✓ for Yes.**

___Rheumatic Fever
___Anemia
___Diabetes
___Mononucleosis
___Tuberculosis
___Temporomandibular Joint Pain
___Tested Positive HIV (AIDS)
___Heart Valve Problems
___Bleeding Tendencies
___Cancer
___High Blood Pressure
___Stomach Ulcers
___Allergies
___Glaucoma
___Hepatitis
___Asthma
___Epilepsy
___Allergic to Anesthetics
___Palpitations

Do you have pain in the face or jaw? __Yes ___No

Does your jaw get stuck where it cannot open/close? ___ Yes ___No

Does jaw click/pop? __Yes ___No Do you have a history of a major condition/illness? ___Yes ___No

Please list any conditions/illnesses: _____

Please list any drug sensitivities/allergies: _____

Please list any medications: _____

Do you take Advil, Motrin or Tylenol on a daily basis? ____Yes ____No

Medical Doctor: _____ Dentist: _____

Reason for visit? _____Who referred you? _____

Patient Signature:_____Dr. Signature:_____

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Patient History Updated on: _____Initials____ _____Intials_____