Michael Cook, DMD **Atenas De Taboada, DMD** **Elizabeth Bacha, DDS**

Date_____

Name: _____ Date of Birth_____

Address: _____

Phone: _____ SSN_____-_____-_____ Sex_____

Married: [Y] or [NO] Email: _____

Previous Dentist Name/Phone Number_____

Insurance Carrier_____ ID_____ Group_____

Insurance Carrier Phone Number _____

Are you Policy Holder? [YES] or [NO] - (IF NO PLEASE FILL OUT BELOW)

Policy Holder Full Name_____ Date of Birth_____

Medical Health:

Name of Physician: _____ Phone Number_____

Have you been under a physician's care during the past 2 years? _____ For_____

Have you been treated in a hospital in the past 2 years? _____ For_____

Have you had major surgery? _____ For: _____

If female: Are you taking hormones or birth control? _____Are you pregnant or nursing_____

Have you had a blood test for hepatitis? _____ Where you vaccinated_____

Have you had canker or cold sores on your lips, tongue, gums, or body? _____

Have you had or do you now have any of the following:

Abnormal Blood Pressure..... [YES] OR [NO]
AIDS..... [YES] OR [NO]
Allergies.....[YES] OR [NO]
Anemia..... [YES] OR [NO]
Angina..... [YES] OR [NO]
Arthritis..... [YES] OR {NO}
Artificial Joints..... [YES] OR [NO]
Artificial Heart Valves..... [YES] OR [NO}
Asthma..... [YES] OR [NO]
Cancer..... {YES] OR {NO}
Chemotherapy..... [YES] OR [NO]
Congenital Heart Lesions..... [YES] OR [NO]
Diabetes..... [YES] OR [NO]
Drug Dependency..... [YES] OR [NO]
Epilepsy..... [YES] OR [NO]
Fainting..... [YES] OR [NO]
Glaucoma..... [YES] OR [NO]
Heart Disease..... [YES] OR [NO]
Heart Murmur..... [YES] OR [NO]
Hepatitis..... [YES] OR [NO]
Herpes..... [YES] OR [NO]
Jaundice..... [YES] OR [NO]
Kidney Disease..... [YES] OR [NO]
Liver Disease..... [YES] OR [NO]
Organ Transplant..... [YES] OR [NO]
Pacemaker..... [YES] OR [NO]
Polio..... [YES] OR [NO]
Prolonged Bleeding..... [YES] OR [NO]
Prolonged Cough..... [YES] OR [NO]
Psychiatric Treatment..... [YES] OR [NO]
Radiation Therapy..... [YES] OR [NO]
Rheumatic Fever..... [YES] OR [NO]
Sickle Cell Anemia..... [YES] OR [NO]
Stroke..... [YES] OR [NO]
Thyroid Disease..... [YES] OR [NO]
Tuberculosis..... [YES] OR [NO]
Ulcers..... [YES] OR [NO]
Venereal Disease..... [YES] OR [NO]

Are you allergic to: { } **Penicillin** { } **Codeine** { } **Local Anesthetics** { } **Other**_____

Dental Health:

When was your last dental visit? _____How often: _____

Do any of the following cause tooth discomfort? Hot _____Cold _____Sweets_____Chewing_____

How often do you brush? _____ Floss _____ Water Jet_____

Do your gums bleed while cleaning? _____Swollen Tenderness in gums? _____

Have you had periodontal treatment? _____ Do you Clench/Grind teeth? ____Jaw click or pop? _____

Have you had orthodontic treatment? (BRACES)_____ If yes When? _____

Do you have any noticeable wear on your teeth? _____ Cracked or broken? _____

Do you have any missing/loose teeth? _____ Food traps? _____

Do you have any Dental Implants? _____Fixed Bridge? _____ Removable parts? _____

Do you have a Removable Partial Denture? _____Full Dentures? _____

How do you feel about the appearance of your smile? _____

Have you had an unpleasant dental experience? _____

Please add anything you feel may be important: _____

Signature_____