Patient Information

_____ M ☐ F ☐ ___/__/____ S ☐ M ☐ D ☐ W ☐
Name (First) (M.I.) (Last) Sex DOB Marital Status

_____
SSN # Email address Home Phone # Cellular # Work #

_____
Home Address (Street) (City) (State) (Zip code)

_____
Name of Employer Occupation If student, name of school

_____
Business Address (Street) (City) (State) (Zip code)

_____/__/_____
Spouse's Name DOB Occupation

_____
Spouse's Employer Work Phone # Cellular #

_____
Emergency contact person Phone # Relationship to you

Whom may we thank for referring you? _____

Dental Health

Reason for your visit: _____ Last teeth cleaning:_____
What is your *primary* concern that you wish us to address first? _____
Have you ever had any problems with previous dental treatment? Yes ☐ No ☐
If yes, please explain here:_____
Are your teeth sensitive? Yes ☐ No ☐
Do your gums feel tender or swollen? Yes ☐ No ☐
Do you feel you don't have fresh breath? Yes ☐ No ☐
How often do you brush your teeth?_____ How often do you floss?_____
What type of bristle do you use? Soft ☐ Medium ☐ Hard ☐
Do you chew on only one side of your mouth? Yes ☐ No ☐
Do you have pain with any of the following: chewing ☐ hot liquids ☐ cold liquids ☐ sweets ☐
Are you missing teeth? Yes ☐ No ☐
Are you aware of grinding or clenching your teeth? Yes ☐ No ☐
Do you often have soreness of your jaws during the day or upon waking? Yes ☐ No ☐
Are you happy with your smile? Yes ☐ No ☐
Would you like to have whiter teeth? Yes ☐ No ☐
If you had a magic wand, what would you change about your smile? _____

Jeffrey A. Diamond, DDS
Legacy Dental Care
158 Second Street, Los Altos, CA 94022

Medical History

General health Excellent ☐ Good ☐ Fair ☐ Poor ☐
Name of physician_____ Telephone number_____
Physician's address_____

Have you ever been hospitalized? Yes ☐ No ☐ If yes, please list reason_____
Are you allergic to any medications? Yes ☐ No ☐ If yes, please list here_____
Are you taking any medications? Yes ☐ No ☐ If yes, please list current medications below:
_____
_____

Do you smoke? Yes ☐ No ☐ If yes, how many cigarettes per day? _____
Females only:
Are you pregnant? Yes ☐ No ☐ If yes, when is the due date? _____
Are you taking any oral contraceptives? Yes ☐ No ☐

Have you ever had any of the following?

Allergy (Hay Fever)	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐
Sinus or Ear Trouble	Yes ☐ No ☐	Blood Disorder (Anemia, Leukemia)	Yes ☐ No ☐
Respiratory Condition	Yes ☐ No ☐	Excessive Bleeding	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Severe or Frequent Headaches	Yes ☐ No ☐
Epilepsy	Yes ☐ No ☐	Abnormal High/Low Blood Pressure	Yes ☐ No ☐
Kidney Disorder or Disease	Yes ☐ No ☐	Thyroid Condition (Hyper/Hypo)	Yes ☐ No ☐
Skin Problem or Disease	Yes ☐ No ☐	Parkinson's Disease	Yes ☐ No ☐
Nervous Disorder, Psychiatric Care	Yes ☐ No ☐	Eye Disease (Glaucoma, Cataract)	Yes ☐ No ☐
Ulcer	Yes ☐ No ☐	Retinal Eye Surgery	Yes ☐ No ☐
Cancer, Tumors, Malignancies	Yes ☐ No ☐	Heart Disease/Condition	Yes ☐ No ☐
X-ray, Radium or Cobalt Treatment	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Herpes, Cold sores, Fever blisters	Yes ☐ No ☐	Scarlet Fever	Yes ☐ No ☐
AIDS or HIV exposure	Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐
Stroke	Yes ☐ No ☐	Transplants	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Artificial Implants (Pacemakers, etc)	Yes ☐ No ☐

If you have answered "yes" to any of the above, please explain here:
_____
_____

What are your hobbies? Special interests?
_____
_____

Signature_____ Date_____