Please complete both sides of this form and bring to your appointment. Also, please read our brochure as it contains important information about your visit. Thank you.

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Please arrive 10 minutes before your appointment time for paperwork.
Thank you.

Today's Date _____

*Patient*_____*Date of Birth* _____
*Address*_____*ZIPCODE*_____
*Home Phone*_____ *Work Phone*_____ *Cell*_____
Height _____ *Weight* _____ *Sex* ____ *Preferred contact phone number/email*_____
Name of Spouse, Parent or Guardian _____
Nearest Relative and/or Friend _____ *Phone No.* _____
*Physicians 1.*_____ *2.*_____ *3.*_____
*Referred By*_____
Dental Policy _____ *ID#*_____ *Policy Holder*_____
Date of Birth of Policy Holder _____ *Social Security Number of Policy Holder* _____

Medical History ***Check all that apply*:**
__ Treatment by any physician now or during the past year: __Routine Other _____
__ History of major surgeries and approximate year: _____
__ Prescribed steroid/cortisone medications for an extended period of time within the past year
__ Taken medications (now or in the past) for bone density/osteoporosis (i.e. Fosamax, Boniva, Actonel, Zometa, etc.)?
__ Diagnosed and/or treated for cancer Type: _____
__ Problem/allergy with latex (i.e. rubber gloves, etc.)
__ Blood clotting problems __Blood pressure concerns/problems
__ Artificial joints __ Artificial heart valve
__ Problems with heart from birth __ History of heart infection __ Heart transplant __ Heart attack __ Stroke
__ Heart bypass surgery __ Heart rhythm problems __ Pacemaker __ Coronary artery stent(s)
__ Lung problems (i.e. asthma, etc.) __ Kidney problems __ Liver problems __ Diabetes or blood sugar problems
__ Lost or gained more than 10 pounds during the past year __ Glaucoma __ History of seizures
__ History of infectious disease (i.e. hepatitis, tuberculosis, HIV, etc.) __ Alcohol/drug dependency problems
__ Environmental/seasonal allergies (i/e. pollen, grass, mold, etc.)
__ Food allergies List: _____
__ Medication(s) that cause you gastrointestinal upset (i.e. nausea, vomiting, diarrhea, etc.) _____
__ Medication allergies (itching, breaking out in hives, swelling, etc.) List: _____

Female only ***Check all that apply:***
__ Birth control pills __ Anticipate future pregnancy __ Pregnant __ Nursing __ Perimenopausal __Postmenopausal
For office use only: _____
_____
_____

Dental History ***Check all that apply:***
In your own words, what is your understanding of why you are here? _____
_____
Are you satisfied with your ability to chew food comfortably? __Yes __No
Are you comfortable with your smile when you look in the mirror? __Yes __No
Do you routinely see a dentist? __Yes __No Dentist's name: _____
__ History of braces __ Complications from dental treatment (infection, dry socket, etc.) __ History of previous gum treatment
__ Problem with agents that make you numb (i.e. Novocain, etc.) for your needed dental work

Dental home care habits ***Check all that apply:***
__ Brush teeth How often: _____ Toothbrush: __ hard __ medium __ soft __ ultrasoft
__ Floss teeth How often: _____ __ Electric toothbrush Brand: _____
__ Interproximal brush __ Rubber tips __ Water-Pik __ Toothpicks __ Other: _____
__ Tobacco use - If so, what kind _____; how much/how often _____

Oral habits and symptoms ***Check all that apply:***
__ Teeth/mouth uncomfortable when chewing __Clench teeth __ Grind teeth __ Awake with sore jaws
__ Teeth sensitivity to: __ Hot __ Cold __Sweets …… __Sometimes __ Most of the time
__ Chronic soreness/discomfort in your jaw joints __Dry mouth __ Cold sores __ Mouth ulcers/canker sores

Please enter below any comments about either your general or dental health history which have not been covered in this questionnaire which concern you or which may influence our treatment for you: _____

--PLEASE COMPLETE OTHER SIDE--

Pain medications you know you have had, and know you can tolerate:

__ Acetaminophen (Tylenol) __ Ibuprofen (Advil, Motrin, etc.) __ Aleve __Aspirin
__ Hydrocodone (Vicodin, Lortab, etc.) __ Oxycodone (Percocet) __ Codeine (Tylenol #3) __ Talacen __Tramadol

Prescription medications, over the counter medications, vitamins, minerals, diet aids, and any other supplements (including herbal)

Please list:

Name	Strength (mg, IU, etc.)	How often	Reason

PLEASE READ AND SIGN:

To my knowledge I have given an accurate report of my health history.
I authorize the release of information to any/all of my healthcare providers and/or my insurance company that is related to my care.
I acknowledge that I have read and understand Dr. Bauman's office brochure detailing his insurance and payment procedures.

Patient's signature: _____ Parent/guardian: _____
Date: _____ Date: _____

Reviewed by: _____
Date: _____