LINDSAY BRISLIN DENTISTRY

NEW PATIENT FORM

Name:		Mobile Phone:	
Bill to:	S.S.#	Home Phone:	
Email:		Business Phone:	
Address:	City:	State:	Zip:
Date of Birth:	Sex:	Height:	Weight:
Occupation:	Employer:		
Relative or Person that can be contacted:		Phone:	
Date:	Referral:		

MEDICAL HISTORY

1.	Has there been any change in your general health within the last year?	☐ Yes	☐ No
2.	Date of last Physical Examination.		
3.	Are you now under the care of a Physlcian?	☐ Yes	☐ No
	If so,for what reason?		
	Name and address of physician.	Phone:	
4.	Have you had any serious illness or operation?	☐ Yes	☐ No
	If so, what was the illness or operation and date?		
5.	Have you had any abnormal or excessive bleeding associated with a previous extraction, surgery or trauma?	☐ Yes	☐ No
6.	Are you currently taking aspirin or another blood thinner?	☐ Yes	☐ No
7.	Are you currently taking any drug or medication?	☐ Yes	☐ No
	If yes please list.		
8.	Are you allergic to any drug or medicine?	☐ Yes	☐ No
	If yes please list.		
9.	Have you been a patient in the hospital during the past two years?	☐ Yes	☐ No
	If yes for what?		
10.	Have you been under the care of a medical doctor during the past two years?	☐ Yes	☐ No
11.	Are you having pain or discomfort at this time?	☐ Yes	☐ No
12.	Date of last dental visit.		
13.	Do you like the appearance of your teeth; your smile?	☐ Yes	☐ No
	If not, explain.		
14.	Do you have spaces that you don't like?	☐ Yes	☐ No
	If yes, explain.		
15.	Do you like the color of your teeth?	☐ Yes	☐ No
	If not, explain.		
16.	Are your teeth ...	☐ chipped? ☐ protruding?	☐ hidden?

17.	Are your teeth wearing on the biting surfaces?	☐ Yes	☐ No
	If yes,explain.		
18.	Do you feel you clench or grind?	☐ Yes	☐ No
19.	Are there old fillings or dental work you don't like looking at?	☐ Yes	☐ No
	If yes, explain.		
20.	What would you like to change the most in the appearance of your teeth?		
21.	Do you feel nervous about having dentistry treatment?	☐ Yes	☐ No
22.	Have you ever had a bad experience in a dental office?	☐ Yes	☐ No
23.	Check any of the following which you have had or have at present:		

☐ Heart Failure	☐ Kidney Trouble	☐ Chemotherapy (Cancer, Leukemia)	☐ Drug Addiction
☐ Heart Disease or Attack	☐ Ulcers	☐ Arthritis	☐ Hemophilia
☐ Angina Pectoris	☐ Emphysema	☐ Rheumatism	☐ Venereal Disease (Syphilis, Gonorrhea)
☐ High Blood Pressure Heart Murmur	☐ Cough	☐ Cortisone Medicine	☐ Cold Sores
☐ Rheumatic Fever Congenital Heart	☐ Tuberculosis (TB)	☐ Glaucoma	☐ Genital Herpes
☐ Lesions Scarlet Fever	☐ Asthma	☐ Pain in Jaw Joints	☐ Epilepsy or Seizures
☐ Artificial Heart Valve	☐ Hay Fever	☐ AIDS	☐ Fainting or Dizzy Spells
☐ Heart Pacemaker	☐ Sinus Trouble	☐ Hepatitis A (infectious)	☐ Nervousness
☐ Heart Surgery	☐ Allergies or Hives	☐ Hepatitis B (serum)	☐ Psychiatric Treatment
☐ Artificial Joint	☐ Diabetes	☐ Liver Disease	☐ Sickle Cell Disease
☐ Anemia	☐ Thyroid Disease	☐ Yellow Jaundice	☐ Bruise Easily
☐ Stroke	☐ X-ray or Cobalt Treatment	☐ Blood Transfusion	☐ H.I.V. Positive

24.	Do you use more than 2 pillows to sleep?	☐ Yes	☐ No
25.	Do you snore?	☐ Yes	☐ No
26.	Have you lost or gained more than 10 pounds in the past year?	☐ Yes	☐ No
	If yes please check "gained" or "lost"	☐ Gained	☐ Lost
27.	Do you ever wake up from sleep short of breath?	☐ Yes	☐ No
28.	Are you on a special diet?	☐ Yes	☐ No
29.	Has your medical doctor ever said you have a cancer or tumor?	☐ Yes	☐ No
30.	Do you have any disease, condition, or problem not listed?	☐ Yes	☐ No
31.	WOMEN: Are you pregnant now?	☐ Yes	☐ No
32.	WOMEN: Are you practicing birth control?	☐ Yes	☐ No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Signature of Patient, Parent or Guardian ______________________________ Date ______________

OFFICE USE ONLY

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

Date	Addition	Signature