



MICHELLE C. JORGENSEN, DDS
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Patient Information

Name: _____ Preferred Name: _____
(Last) (First) (Middle)

Sex M F Age _____ Birth date: _____ Soc. Sec. # _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____ Other Phone: _____

Best Way to Contact for Appointment Reminder: Phone Call Text Email

Occupation: _____ Employer: _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Relation: _____ Home Phone: _____

Dental History

How would you like us to help you today? _____

How would you rate your oral health right now on a scale of 1 – 10, 10 being the best? _____

What would you like to change about your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? _____

If yes, please explain _____

Other information about your dental health or previous treatment _____

Medical Information

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Headaches | <input type="checkbox"/> Metal allergies |
| <input type="checkbox"/> Alcohol or drug dependency | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Osteoporosis therapy |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophilia/abnormal bleeding | <input type="checkbox"/> Skin rash to metal jewelry |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Tobacco habit |

Other diseases: _____

Please list medical medications you are taking if any: _____

Please list drug allergies if any: _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that the dentist will use this information to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature of Patient, Parent or Guardian _____ Date _____