MORRISON
Dental Care
Your trusted source for a world-class smile

Welcome to Morrison Dental Care!

Thank you for choosing us to assist in caring for your Oral Health. At Morrison Dental Care, we strive to help you achieve an esthetic, comfortable, functional, and healthy smile. As one of the few entry-points into your body, the health of your mouth is linked in countless ways to your overall health. As such, please help us learn your current oral and overall health needs and goals.

Name: _____

First Last MI

How Were You Referred to Our Office? _____

Please Explain What Goals/Concerns Brought You In: _____

_____

Patient Information:

Birthday: _____ SS: _____ Sex: _____

Address: _____

Street City State Zip Code

Phone: Home: _____ Work: _____ Mobile: _____

Email Address: _____ Married Single Divorced Widowed

How Would You Like to be Contacted: Phone? Yes/No E-Mail? Yes/No Text? Yes/No

Occupation: _____ Employer: _____

Person to Contact in Case of Emergency: _____

Dental History:

Are you having any pain or sensitivity or sensitivity right now? YES NO _____

Who was your previous dentist? _____ When was your last visit? _____

Have you had any difficulty with previous dental treatment? _____

Do you have, now or in the past, any of the following disease or problems? Please CIRCLE if YES:

Bad Breath	Dry Mouth	Food Collection Between Teeth
Swollen, Tender, or Bleeding Gums	Snoring	Sores or Growths in Your Mouth
Hot or Cold Sensitivity	Loose Teeth	Jaw Pain, Clicking, or Headaches
Broken Teeth or Fillings	Sleep Apnea	Grinding or Clenching

Have you ever been treated for periodontal disease? YES NO _____

Have you ever had orthodontic treatment (Braces or Invisalign)? YES NO _____

Are you happy with the appearance of your teeth? _____

Please Turn Over

Medical History:

Who is your Primary physician? _____ Phone #: _____ Last Visit: _____

Secondary physician? _____ Specialty: _____ Phone #: _____

Has there been a change in your general health within the past year? YES NO

Have you been hospitalized or had a serious operation or illness within the last 5 years? YES NO

Do you have or have you had any of the following diseases or problems? Please circle if YES:

High Blood Pressure	Heart Disease	Chest Pain
Heart Attack	Cardiac Pacemaker	Stroke
Rheumatic Fever	Heart Murmur	Hay Fever / Allergies
Fainting / Seizures/Epilepsy	Angina	Chemotherapy
Asthma	Cancer	Tuberculosis
Leukemia	Arthritis	Radiation Therapy
Diabetes	Joint Replacement	Glaucoma
Kidney Diseases	Hepatitis / Jaundice	Liver Disease
AIDS / HIV Infection	Sexually Transmitted Disease	Respiratory Problems
Thyroid Problem	Stomach Troubles / Ulcers	Other

Are you taking any medication, including non-prescription? YES NO If so, what?

Are you allergic or have you reacted adversely to any drugs or medicines: YES NO

Aspirin Penicillin Latex Rubber Local Anesthetic (Novocain)
Any Metals Other Antibiotics Iodine Sleeping Pills
Other: _____

Have you taken Fosamax, Boniva, any other Bisphosphonate medication? YES NO

Do you use tobacco or any other controlled substances? YES NO

If so, please explain _____

Have you had abnormal bleeding associated with previous extractions, surgery, trauma? YES NO

Have you been told you needed to pre-medicate with antibiotics before dental treatment? YES NO

Do you sleep well at night? YES NO Do you snore? YES NO

Do you have a disease, condition, or problem not listed above that you think we should know?

FOR WOMEN ONLY: ARE YOU PREGNANT? YES NO If yes, what month? _____

Are you taking birth control pills YES NO

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____

Signature of Patient or Guardian Date