Welcome to the office of

Loren C. Baim, D.D.S.

Date: _____ Date of Birth _____

Name: _____ Social Security # _____

Address: _____

City: _____ State _____ Zip _____ Phone _____

School: _____

Employed by: _____ Phone _____

Sex _____ Height _____ Weight _____ Marital Status: S M D W

Spouse's Name _____ Social Security # _____

Spouse's Employer _____ Phone _____

Who will pay for this account? _____

Name of Dental Insurance Co(s).

Yours _____ Group No. _____ Ident. No. _____

Spouses _____ Group No. _____ Ident. No. _____

Whom may we thank for referring you to our office? _____

Medical History

Do You or Have You Ever Had Any of the Following?

	YES	NO		YES	NO
Heart Problems	☐	☐	Recurring Sores	☐	☐
High Blood Pressure	☐	☐	Oral Herpes	☐	☐
Low Blood Pressure	☐	☐	Fainting Spells	☐	☐
Heart Murmur	☐	☐	Nervous Problems	☐	☐
Anemia	☐	☐	Radiation Treatment	☐	☐
Rheumatic Fever	☐	☐	Arthritis	☐	☐
Frequent Nose Bleeds	☐	☐	Venereal Disease	☐	☐
Prolonged Bleeding	☐	☐	Diabetes	☐	☐
Bruise Easily	☐	☐	Hepatitis	☐	☐
Asthma	☐	☐	Glaucoma	☐	☐
Allergy to Local Anesthesia	☐	☐	Excess Urination or thirst	☐	☐
Allergy to Medication or Drugs	☐	☐	Sinus Problems	☐	☐
Allergy to _____	☐	☐	Stroke	☐	☐
Reaction to Medication or Drugs	☐	☐	Tonsilitis	☐	☐
Epilepsy	☐	☐	Tuberculosis	☐	☐
Blood Transfusions	☐	☐	Ulcer	☐	☐
			HIV	☐	☐

Date of Last Physical Exam _____ Physician _____

Are you taking any medications now? yes ☐ no ☐ For what reasons? _____

Are you taking hormones? _____; Vitamins? _____; Birth Control Pills? _____; Aspirin? _____

Are you under a physician's care? yes ☐ no ☐ For what reason? _____

Women - are you pregnant? yes ☐ no ☐ Due Date _____

Are you in good health yes ☐ no ☐ Any change in past year yes ☐ no ☐

Habits - Smoke _____; Chewing Tobacco _____; Alcohol _____; Drugs _____

Please describe any current medical treatment, impending operation, or any other medical or dental information that may possibly affect your dental treatment. _____

_____

_____

Authorization for release of information and assignment of benefits to dentist in the existence of insurance coverage.

Signature _____

Dental Health

Purpose of visit _____

Previous dentist _____ Date of last dental treatment _____

What was done? _____

Have you ever had any serious problems associated with previous dental visits? yes ☐ no ☐ Explain _____

How often do you brush? _____ Floss? _____

Do your gums bleed when brushing? yes ☐ no ☐ Flossing? yes ☐ no ☐

Do you chew on one side of your mouth? yes ☐ no ☐

Why? Pain yes ☐ no ☐ Lack of Teeth? yes ☐ no ☐ TMJ? yes ☐ no ☐ Other _____

Do you avoid brushing any part of your mouth due to pain? yes ☐ no ☐

If yes, explain _____

Do your gums feel tender or swollen? yes ☐ no ☐

Do you clench or grind your teeth while asleep? yes ☐ no ☐ While Awake? yes ☐ no ☐

Do your jaws ever feel tired? yes ☐ no ☐

Do you usually have many cavities? yes ☐ no ☐

Do you lose or break fillings? yes ☐ no ☐

Do you gag easily? yes ☐ no ☐

Are you aware of any swelling or lump in your throat? yes ☐ no ☐

Have you been satisfied with your dental treatment in the past? yes ☐ no ☐

Have you had any of the following?

periodontal treatment yes ☐ no ☐ oral surgery (including extractions) yes ☐ no ☐

orthodontic treatment yes ☐ no ☐ endodontic treatment (root canals) yes ☐ no ☐

If anything - what would you change about your smile? _____

_____

_____

Please add anything that you feel important _____

_____

_____