MYRNA E. LAZAGA D.M.D..

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Welcome to our office. We appreciate the confidence you place with us to provide you with dental services. To assist us in serving you, please complete the following forms. The information provided on this form is important to your dental health. If there have been any changes in your health, please let us know. If you have any questions, don't hesitate to ask.

Patient Name:____________________ Date of Birth: __________ Age: ______

Home Address: ____________________ City: __________ State: ____ Zip: ______

Mailing Address (If different): ________________ City: __________ State: ____ Zip: ______

Home Telephone: __________ Work Phone: __________ Cell Phone: ________________

Driver's License #: ________________ State: ______ Social Security #: ________________

Spouse's Name & Phone #: ________________________ Email: ______________

Employer/Occupation: ____________________ Emergency Contact & Phone:________________

Primary Dental Insurance: __________________ Secondary Insurance (If any): ________________

Subscribers Name: ____________________ Date of Birth: ________ S.S. #: ____________

Name of Primary Physician: __________________ Physician Phone #: ____________________

Name of Previous Dentist: __________________ Date of last visit to Dentist: ________________

How did you learn of our office? ____

DENTAL HEALTH HISTORY

Please Mark any that Apply:	Yes	No	Please Mark any that Apply:	Yes	No
Are you apprehensive about dental treatment?			How often do you brush?		
Have you had problems with previous dental treatment?			How often do you floss?		
Do you gag easily?			Does your jaw make noises so that it bothers you or others?		
Do you wear dentures?			Do you clench or grind your jaws frequently?		
Does food catch between your teeth?			Does your jaw ever feel tired?		
Do you have difficulty chewing your foods?			Does your jaw get stuck so that you can't open freely?		
Do you chew on only one side of your mouth?			Does it hurt when you chew or open wide to take a bite?		
Do you avoid brushing any areas due to pain?			Do you have earaches or pain in front of the ears?		
Do your gums bleed easily?			Do you have any jaw symptoms or headaches upon waking in the morning?		
Do your gums bleed when you floss?					
Do your gums feel swollen or tender?			Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?		
Are your teeth sensitive?					
Have you ever noticed slow-healing sores in or about your mouth?			Do you find jaw pain or discomfort extremely frustrating or depressing?		
Do you feel twinges of pain when your teeth come in contact with:			Do you take medications or pills for pain or discomfort? (pain relievers, muscle relaxants, antidepressants)		
- Hot foods or liquids?			Do you have temporomandibular jaw disorder? (TMD, TMJ)		
- Cold foods or liquids?			Do you have pain in the face, cheeks, jaws, joints, throat or temples?		
- Sours?					
- Sweets?			Are you unable to open your mouth as far as you want?		
Do you take fluoride supplements?			Are you aware of an uncomfortable bite?		
Are you dissatisfied with the appearance of your teeth?			Have you had a blow to the jaw (trauma)?		
Do you prefer to save your teeth?			Are you a habitual gum chewer or pipe smoker?		
Do you want complete dental care?					

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?

Please mark any that apply.	Yes	No	Please mark any that apply	Yes	No
Heart problems			Diabetes		
Chest pain			Urinate more than 6 times a day		
Shortness of breath			Thirsty or mouth is dry much of the time		
Blood pressure problems			Family history of diabetes		
Heart Murmur			Tuberculosis or other respiratory disease		
Heart valve problem			Do you drink alcohol?		
Taking heart medication			If so, how much		
Rheumatic fever			Do you smoke		
Pacemaker			If so, how much		
Artificial heart valve			Hepatitis, jaundice, or liver trouble		
Blood problems			Herpes or other STD's		
Easy bruising			HIV positive/AIDS		
Frequent nosebleeds			Glaucoma		
Abnormal bleeding			Do you wear contact lenses		
Blood disease (anemia)			History of head injury		
Ever required blood transfusion			Epilepsy or other neurological disease		
Allergy Problems			History of alcohol or drug abuse		
Hay fever			Do you have any disease, condition, or problems not listed previously that you feel we should know about?		
Sinus problems					
Skin rashes			If so, please describe		
Taking allergy medication					
Asthma					
Intestinal problems					
Ulcers			**During the past 12 months, have you taken any of the following?**		
Weight gain or loss					
Special diet			Antibiotics or sulfa drugs		
Constipation/Diarrhea			Anticoagulants (e.g. Coumadin)		
Kidney or bladder problems			High blood pressure medicine		
Bone or joint problems			Tranquilizer		
Arthritis			Insulin, Orinase, or similar drug		
Back or neck pain			Aspirin		
Joint replacement (e.g. hip, pins, implants)			Digitalis or drugs for heart trouble		
Fainting spells, seizures, or epilepsy			Nitroglycerin		
Frequent or sever headaches			Cortisone (steroids)		
Thyroid problems			Bisphosphonates (e.g. Fosamax, Boniva, Actonel)		
Persistent cough or swollen glands			Natural Remedies		
Premeditation required by physician			Nonprescription drug/supplements		
Cancer/tumor			Other		
Are you allergic, or have you reacted adversely to any of the following?					
Local anesthetics (Novocain)					
Penicillin or other antibiotics			**Women**		
Sulfa drugs			Are you taking contraceptives or other hormones		
Barbiturates, sedatives, or sleeping pills			Are you pregnant		
Aspirin, acetaminophen, or ibuprofen			If so, expected delivery date		
Codeine, Demerol, or other narcotics			Are you nursing		
Reaction to metals			Have you reached menopause		
Latex or rubber dam			If so, do you have symptoms		
Other (please list)			(please describe)		

Patient/Guardian Signature ____________________ Date ____________________ Dentist Initial ____________________