Gerardo L. Beauchamp, D.D.S.
Family and Cosmetic Dentistry

We are pleased to welcome you to our practice. Please take a few minutes to answer these questions as completely as you can. The information on this form is necessary for our records. It is considered strictly confidential. We look forward to working with you in maintaining your dental health.

NAME: _____ DATE OF BIRTH: _____/_____/_____
Last First Middle AGE: _____
ADDRESS: _____
Street City State Zip Code
HOME PHONE:(___)_____ BUSINESS PHONE:(___)_____
EMPLOYED BY: _____
Name Address
DENTAL INSURANCE: _____ Soc.Sec.#_____-_____-_____
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

MEDICAL HISTORY

Circle

1. Have you ever been hospitalized and was surgery performed?..... Yes No
   Please specify _____
2. Is your physician treating you now?..... Yes No
   Please specify _____
3. Do you have heart disease or a heart murmur?..... Yes No
4. Do you become breathless easily?..... Yes No
5. Have you had abnormal bleeding?..... Yes No
6. Have you ever tested positive to the HIV (AIDS) virus or ARC?..... Yes No
7. Are you currently being treated for the HIV (AIDS) virus or ARC?..... Yes No
8. Have you taken cortisone or steroids?..... Yes No
9. Have you any allergies?..... Yes No
10. Have you had an allergic reaction to any drugs or medicines e.g. penicillin?..... Yes No
    Please specify_____
11. Are you taking any prescription drugs or medicines?..... Yes No
    Please specify_____
12. Do you have or have you had? (Circle all that apply.)

Persistent cough	Recurrent fever	Anorexia
Bloody phlegm	Night sweats	Weight loss
Heart trouble or chest pain	Epilepsy	AIDS
High blood pressure	Thyroid trouble	Blood disorders
Kidney trouble	Tuberculosis	Diabetes
Liver trouble (e.g. jaundice, hepatitis)	Asthma	Anemia
Cancer	Venereal diseases (syphilis,	Any other:_____
Rheumatic fever	gonorrhea)	_____

13. Is there any history of family disease?..... Yes No
14. Is there anything else you think you should tell us?..... Yes No

DENTAL HISTORY

1. Have you been under regular dental care by a dentist? ..... Yes No
2. When was your last visit and for what? _____
   _____
3. Have you ever had local anesthesia, such as Novocaine? ..... Yes No
4. Were there any complications? ..... Yes No
   Please explain _____
5. Have you ever had any teeth extracted? ..... Yes No
6. Were there any complications? ..... Yes No
   Please explain _____
7. Do any of your teeth hurt? ..... Yes No
8. Do your gums feel swollen, or bleed, when you brush? ..... Yes No
9. Do you wear any partial or complete dentures? ..... Yes No
10. Do you have any loose teeth? ..... Yes No
11. Did you have "braces," or Orthodontic treatment? ..... Yes No
12. Does your bite ever feel awkward or uncomfortable? ..... Yes No
13. Does your jaw click or pop when you open or close? ..... Yes No

GENERAL QUESTIONS

1. Are you tense during dental visits?..... Yes No
2. Are you happy with the appearance of your teeth?..... Yes No
3. Are you interested in bleaching or teeth whitening?..... Yes No
4. Do you take vitamins and/or minerals? ..... Yes No
   Which types? _____
5. Do you floss? How often? _____ Yes No
6. Do you use an electrical toothbrush? ..... Yes No
7. How often do you brush? _____

FOR WOMEN ONLY

1. Are you pregnant? If so, how far along? _____ Yes No
2. Are you currently taking birth control pills? _____ Yes No
3. Have you had a hysterectomy? _____ Yes No
4. Have you reached menopause? _____ Yes No
5. Are you taking estrogen or any other hormonal therapy? _____ Yes No
6. Do you have an OB/GYN? _____ Yes No
   Please provide name : _____
   phone # : (___)_____-_____

MISCELLANEOUS

Do you have an e-mail address?..... Yes No
May we have it , please? _____

Patient's Signature: _____ Date: _____/_____/_____