WELCOME

To help us meet all of your dental healthcare needs, please fill out this form completely. This information is vital to provide appropriate care for you. If you have any questions or need assistance, please ask us - we will be happy to help. Our office adheres to written policies to protect the privacy of information about you that we create, receive or maintain.

PERSONAL PATIENT INFORMATION

Name: _____ Preferred Name: _____

Birthdate: _____/ _____/ _____ SS#: _____-_____ - _____ M: _____ F: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Where do you prefer to receive calls: _____ Home _____ Cell _____ Work

Email: _____

How would you like to receive appointment reminders?: (Check all that apply) Phone _____ Text _____ Email _____

Person Completing Form - Name: _____ Relationship to Patient: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Referred by: ex: Patient name / Online / insurance _____

DENTAL INFORMATION

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets, pressure?	☐	☐
Does food or floss catch between your teeth?	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐
Have you had problems with previous dental care?	☐	☐
Is your home water supply fluoridated?	☐	☐
Do you drink bottled or filtered water?	☐	☐

If yes how often? Circle one: Daily Weekly Occasionally

	Yes	No
Are you now experiencing dental pain or discomfort?	☐	☐
Do you have headaches, earaches or neck pain?	☐	☐
Do you have any clicking or discomfort in the jaw?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials? (please circle)	☐	☐
Do you participate in active recreational activities?	☐	☐
Have you ever had an injury to your head or mouth?	☐	☐

What is the reason for your visit today? _____

_____

How do you feel about your smile? _____

Date of your last dental exam: _____

What was done at that time? _____

_____

_____

Date of last dental xrays: _____

_____

MEDICAL INFORMATION

	Yes	No
Are you now under the care of a physician?	☐	☐
Are you in good health?	☐	☐
Any change in your general health in the past year?	☐	☐

Physician:

_____

City / State / Phone Number

_____

If yes, what condition is being treated?

_____

Date of last physical exam?

_____

	Yes	No
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐
Are you taking any prescription or over the counter medicines?	☐	☐

If yes, what was the illness or problem:

_____

_____

If yes, please list: (more space below) _____

_____

_____

_____

Medications continued: _____

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Joint Replacement Have you had a total joint (hip,knee, etc.) replacement? Yes ☐ No ☐

Bone Health

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ ☐

Since 2001, were you treated or are your presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐

Date Treatment began? _____

Women Only Are you:

Pregnant? _____ ☐ ☐

Number of weeks:? _____

Taking birth control pills or hormonal replacement? ☐ ☐

Nursing? ☐ ☐

Allergies Are you allergic to or have you had a reaction to: Yes ☐ No ☐

To all yes responses, specify type of reaction?

Local anesthetics? _____ ☐ ☐

Aspirin? _____ ☐ ☐

Penicillin or other antibiotics? _____ ☐ ☐

Codeine or other narcotics? _____ ☐ ☐

Metals? _____ ☐ ☐

Latex (rubber)? _____ ☐ ☐

Hay Fever / Seasonal? _____ ☐ ☐

Other? _____ ☐ ☐

Sleep

	Yes	No
Do you snore?	☐	☐
Are you tired during the day?	☐	☐
Do you have trouble sleeping through the night?	☐	☐
Do you wake-up with a headache?	☐	☐
Have you had a sleep study?	☐	☐
Do you have a CPAP machine?	☐	☐

Cardiovascular

	Yes	No
Cardiovascular disease	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Artificial Heart Valve*	☐	☐
Bypass Stent	☐	☐
Chest Pain on Exertion	☐	☐
Congenital Heart Disease	☐	☐
-Unrepaired Cyanotic	☐	☐
in last 6 months	☐	☐
-Repaired CHD with residual defects*	☐	☐
Congestive Heart Failure	☐	☐
Damaged Heart Valves in Transplanted Heart*	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Mitral Valve Prolapse	☐	☐
Pacemaker	☐	☐
Previous Infective Endocarditis*	☐	☐

Cardiovascular Cont.

	Yes	No
Other Congenital Heart Defects	☐	☐
Rheumatic Fever / Disease	☐	☐
Stroke	☐	☐

**These are the only conditions where antibiotic prophylaxis is still recommended.*

Respiratory

Asthma	☐	☐
COPD	☐	☐
Emphysema	☐	☐
Sinus Troubles	☐	☐
Tuberculosis	☐	☐

Musculo-Skeletal / CNS / Development

Arthritis	☐	☐
Cerebral Palsy	☐	☐
Chronic Pain	☐	☐
Dementia	☐	☐
Epilepsy / Seizures	☐	☐
Mentally Handicapped	☐	☐

Endocrine / Hematologic / Oncologic / Immune

Abnormal Bleeding	☐	☐
Anemia	☐	☐
Autoimmune Disease	☐	☐
Blood Transfusion	☐	☐
Stem Cell Therapy	☐	☐
Cancer / Chemo / Radiation	☐	☐
Diabetes - Type I or Type II	☐	☐
Excessive Urination	☐	☐
Hemophilia	☐	☐
HIV / AIDS	☐	☐
Kidney Problems	☐	☐
Lupus	☐	☐
Multiple Sclerosis	☐	☐
Organ Transplant	☐	☐
Osteoporosis / Osteopenia	☐	☐
Recurrent Infection	☐	☐
Sickle Cell Disease	☐	☐
Thyroid Disease	☐	☐

GI / GU

Crohn's Disease	☐	☐
GI Disease	☐	☐
Hepatitis	☐	☐
Jaundice	☐	☐
Kidney Dialysis	☐	☐
Liver Disease	☐	☐
Reflux or Heartburn	☐	☐
STDs	☐	☐
Ulcers	☐	☐

Psychosocial

Alcohol - How much?	☐	☐
Anxiety / Nervousness	☐	☐
Chronic Pain	☐	☐
Depression	☐	☐
Eating Disorder	☐	☐
Neurologic Disorders	☐	☐
Recreational Drugs	☐	☐
Sleep Disorder	☐	☐
Tobacco Products	☐	☐
Vaping	☐	☐

Do you have any disease, condition, or problem not listed above that you think we should know about? Please Explain _____

_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment: ☐ ☐

Name of physician or dentist making recommendation: _____ Phone: _____

Comments: _____

_____

X _____ DATE _____ X _____ DATE _____
SIGNATURE Update Signature

X _____ DATE _____ X _____ DATE _____
Update Signature Update Signature

X _____ DATE _____ X _____ DATE _____
Update Signature Update Signature

X _____ DATE _____ X _____ DATE _____
Update Signature Update Signature