Welcome

We are glad you chose us for your family dental care. It is our main goal to meet all of your general and preventive dental healthcare needs. In order for us to do this, please fill out this form completely and return it to the receptionist. The better we communicate, the better we can care for you. All information is, of course, confidential. If you need any assistance, please ask us – We will be happy to help.

PATIENT INFORMATION Date:______________________

Name:____ Home #:____________________________________

Birth date: _____/_____/_____ Soc Sec#:____________________________ Cell #:____________________________

Sex:______ Weight:________ Height:______ Email:____

Address:____

(Include City, State, and Zip Code)

Employer:____ Work #:_________________________________

Emergency Contact:____________________________________ Relationship:_________________________________

Emergency Contact #:______________________________ Insurance Name:__________________________________

Dental History

Date of last dental visit:________________ Previous Dentist's Name:____________________________________

How often do you brush?:____________________________ Floss?:_________________________________

Have you ever:

Yes Or No:

☐ ☐ Had a problem with bleeding?

☐ ☐ Had a problem with swelling?

☐ ☐ Had a problem with drug reaction?

☐ ☐ Had a problem with dry socket?

☐ ☐ Been instructed regarding proper home care of your teeth or gums?

☐ ☐ Do you frequently get cold sores, blisters, or other oral lesions?

☐ ☐ Do you smoke or chew tobacco?

☐ ☐ Had a serious injury to your mouth?

☐ ☐ Had a serious injury to your jaw?

☐ ☐ Had a serious injury to your head?

☐ ☐ Had a serious injury to your face?

☐ ☐ Had full or partial dentures? **If yes, how long**? ___________________

☐ ☐ How long have you worn your current prosthesis?

☐ ☐ Have you ever had a reline?

☐ ☐ Are you presently having any problems with your dentures?

☐ ☐ Felt nervous about having dental treatment?

MEDICAL HISTORY

Physician's Name:_______________________________________ Phone #:__________________________________

Yes or No:

Yes	No	
☐	☐	Have you ever been told you need Antibiotic Prophylaxis (pre-medication) prior to any dental treatment?
☐	☐	Do you consider yourself to be in good health?
☐	☐	Are you currently under a physician's care?
☐	☐	Do you or have you taken Fosamax?
☐	☐	Are you currently taking any medications? If yes, please list below:

____

____

Are you aware of having an allergic or adverse reaction to any of the following:

☐ Penicillin ☐ Tetracycline ☐ Sulfa ☐ Erythromycin ☐ Latex

☐ Aspirin ☐ Dental Anesthetics ☐ Codeine ☐ Metals ☐ Other

Females: Are you: ☐ pregnant? ☐ nursing? ☐ Taking birth control pills?

Indicate which of the following you have had, or have at present:

☐ Heart(surgery, disease, attack)	☐ Ulcers	☐ Back/Neck Problems
☐ Chest Pain	☐ Diabetes	☐ Hepatitis
☐ Congenital Heart Disease	☐ Thyroid Problems	☐ Venereal Disease
☐ Heart Murmur	☐ Glaucoma	☐ AIDS/HIV Positive
☐ Low Blood Pressure	☐ Congestive Heart Failure	☐ Cold Sores/Fever Blisters
☐ High Blood Pressure	☐ C.O.P.D.	☐ Blood Transfusion
☐ Mitral Valve Prolapse	☐ Emphysema	☐ Hemophilia
☐ Artificial Heart Valve	☐ Chronic Cough	☐ Sickle Cell Disease/Trait
☐ Heart Pacemaker	☐ Tuberculosis	☐ Bruise Easily
☐ Rheumatic Fever	☐ Asthma	☐ Liver Disease
☐ Arthritis/Rheumatism	☐ Yellow Jaundice	☐ Cortisone Medication
☐ Allergies or Hives	☐ Neurological Disorders	☐ Swollen Ankles
☐ Sinus Trouble	☐ Epilepsy/Seizures	☐ Leukemia
☐ Radiation Therapy	☐ Fainting or Dizzy Spells	☐ Stroke
☐ Diet (Restricted/Special)	☐ Chemotherapy	☐ Nervous/Anxious
☐ Artificial Joints(hip, knee, etc)	☐ Tumors/Cancer	☐ Psychiatric/Psychological Care
☐ Kidney Disease	☐ Drug/Alcohol Abuse	☐ Other?____________________

Patient or Responsible Party Signature: ____

Responsible Party (Parent or if different than Patient**):**

Name:____ Relationship to Patient:_________________________________

SSN#:_________________________ Birth date:___________________ Driver's License #:________________________