PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents names _____ Home phone _____ Cell phone _____

Email Address_____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____Work phone _____

Social Security number _____ How did you hear about us?_____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following? (Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart disease or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Stroke
- ❑ Heart attack
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis
- ❑ Lung disease/ emphysema
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Sexually transmitted disease
- ❑ Stomache ulcers/ GERD
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Radiation therapy
- ❑ Glaucoma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Thyroid problems
- ❑ Other:_____
- ❑ Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin
- ❑ Other Antibiotic (please list)_____
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Please list all medication you are currently taking including non-prescription medicine:

_____

_____

_____

Women:

- ❑ Are you pregnant or think you may be pregnant? Expected delivery date: _____
- ❑ Are you nursing?
- ❑ Taking hormones or contraceptives? List:_____

PATIENT DENTAL HISTORY

Do you snore or stop breathing in your sleep? Yes/ No

- ❑ My gums bleed while brushing or flossing
- ❑ My teeth are sensitive to hot or cold liquids/foods
- ❑ I feel pain in my teeth
- ❑ I have sores or lumps in or near my mouth
- ❑ I have been diagnosed with gum disease
- ❑ I have frequent headaches
- ❑ I clench or grind my teeth
- ❑ I bite my lips or cheeks frequently
- ❑ I've had difficult extractions in the past
- ❑ I've had orthodontic treatment
- ❑ I've had head, neck or jaw injuries
- ❑ I've experienced the following problems in my jaw:
  - ❑ Clicking
  - ❑ Pain (joint, ear, side of face)
  - ❑ Difficulty in opening or closing
  - ❑ Difficulty in chewing
- ❑ I've had no instruction on the correct method of brushing my teeth
- ❑ I've had no instruction on the proper care of my gums

Name of your physician:_____Office Phone:_____Date of last exam:_____

Do you have any disease, condition, or problem not listed above?_____

_____

Signature of patient (or parent) _____ Date _____