FAMILY DENTISTRY ASSOC.

PATIENT INFORMATION Date: _______________

Name: ____ Age:______ Sex:______

Last First Middle

Address: ____

Street City State/Zip

Phone: ____________________________ Email: _______________________________

Social Security Number: ____

Employer: _______________________________ Occupation: ___________________

Emergency Contact

Name: ____

Relationship to Patient: ____

Phone: ____

Person Responsible for Payment (if different than information listed above)

Name: ____ Relationship: _________________

Address: ____

Street City State/Zip

Phone: ____________________________ Email: _______________________________

Social Security Number: ____

Employer: ____

Bill will be paid by: ___ Cash ___ Credit/Debit Card ___ Insurance

Insurance Company: ____

Policy # _________________________ In whose name is policy carried: ____________________

FAMILY DENTISTRY ASSOC.

DENTAL HISTORY

What is the reason for you dental visit today? ______________________________

How often do you see a dentist? ______________________________

When was your last dental visit? ______________________________

What was done at that visit? ______________________________

Do you wear dentures or partials? ☐ Yes ☐ No

Are you currently experiencing any pain or discomfort? ☐ Yes ☐ No

Do your gums bleed when you brush or floss? ☐ Yes ☐ No

Are your teeth sensitive to cold, hot, sweets, or biting? ☐ Yes ☐ No

Is your mouth excessively dry? ☐ Yes ☐ No

Have you ever had periodontal (gum) surgery? ☐ Yes ☐ No

Are you apprehensive about dental care? ☐ Yes ☐ No

Do you have any clicking popping, or discomfort in your jaw? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you get sores or ulcers in your mouth? ☐ Yes ☐ No

How do you feel about your smile? ______________________________

How often do you brush your teeth? ______________________________

What kind of toothpaste do you use? ______________________________

How often do you floss? ______________________________

Do you use a mouth rinse? ______________________________

If so, what kind? ______________________________

How many snacks do you have per day? ______________________________

What do you normally snack on? ______________________________

How many beverages do you have per day? ______________________________

What do you normally drink? ______________________________

Do you drink mostly bottled water or tap water? ______________________________

FAMILY DENTISTRY ASSOC.

MEDICAL INFORMATION

1. Are you in good health? ☐ Yes ☐ No

   If no/don't know, please explain. ____________________

2. Have there been any changes in your general health within the past year? ☐ Yes ☐ No

   If yes, please explain. ____________________

3. Are you now under the care of a physician? ☐ Yes ☐ No

   Physician or clinic name: ____________________ Phone: ____________

   Physician or clinic name: ____________________ Phone: ____________

   Physician or clinic name: ____________________ Phone: ____________

4. Have you had any serious illness, operation, organ transplant, or been hospitalized in the past 5 years? ☐ Yes ☐ No

   If yes, what was the illness or problem? ____________________

5. Have you had any cancer, tumor, or malignancy? ☐ Yes ☐ No

   If yes, type, when, treatment ____________________

6. Are you taking any medications, including non-prescription medicine? ☐ Yes ☐ No

   If yes, please list all, including prescribed, over-the-counter, vitamins, & natural or herbal supplements.

NAME	DOSAGE	FREQUENCY

FAMILY DENTISTRY ASSOC.

7. Do you drink alcohol? ☐ Yes ☐ No

   Are you alcohol dependen? ☐ Yes ☐ No

   If yes, are you receiving treatment? ☐ Yes ☐ No

8. Do you use drugs or other substances for recreational purposes? ☐ Yes ☐ No

   Frequency of use: ____________________

   Number of years of recreational drug use: ____________________

   Are you drug dependent? ☐ Yes ☐ No

   If yes, are you receiving treatment? ☐ Yes ☐ No

9. Do you smoke, use smokeless tobacco, or electronic cigarettes? ☐ Yes ☐ No

   If yes, type, how much/often, packs/per day: ____________________

   If yes, how interested are you in stopping? VERY SOMEWHAT NOT INTERESTED

10. Allergies: Are you allergic to or have you had a reaction to:

Latex	☐ Yes ☐ No	Sulfa drugs	☐ Yes ☐ No
Local anesthetic	☐ Yes ☐ No	Codeine	☐ Yes ☐ No
General anesthetic	☐ Yes ☐ No	Seasonal	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No	Animals	☐ Yes ☐ No
Penicillin	☐ Yes ☐ No	Food (specify)	☐ Yes ☐ No
Other antibiotics	☐ Yes ☐ No	Metals (specify)	☐ Yes ☐ No
		Other (specify) ____________	

11. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No

   If yes, what antibiotic and dose? ____________________

   Name of physician making recommendation: ____________________

   Phone number: ____________________

12. Women Only: Are you or could you be pregnant? ☐ Yes ☐ No

   Number of weeks: ____________________

   Nursing? ☐ Yes ☐ No

   Taking birth control or hormonal replacement? ☐ Yes ☐ No

FAMILY DENTISTRY ASSOC.

SYSTEMS

CARDIOVASCULAR

	Y	N
Hypertension		
Blood thinner		
Congestive heart failure		
Rheumatic heart disease		
Angina or chest pain		
Myocardial infarction (heart attack)		
Heart surgery		
Coronary bypass surgery		
Stents		
Infective endocarditis		
Congenital heart defect		
Prosthetic heart valve		
Heart transplant		
Pacemaker/defibrillator		
Other		

HEMATOLOGIC

	Y	N
Blood transfusion		
Anemia		
Leukemia		
Sickle cell disease		
Bleeding tendencies		
Clotting disorders		
Other		

GENTINOURINARY

	Y	N
Kidney problems		
Dialysis		
Sexually transmitted disease		
Other		

NEUROLOGIC

	Y	N
Stroke/CVA		
Shingles		
Seizures/epilepsy		
Psychiatric treatment		
Convulsions		
Other		

GASTROINTESTINAL

	Y	N
Stomach ulcers		
Gastritis/colitis		
GERD/reflux		
Hepatitis		
Liver disease		
Other		

IMMUNE SYSTEM

	Y	N
HIV positive		
AIDS		
Sjogren’s syndrome		
Systemic lupus erythematosus		
Immunosuppressant drugs		

ENDOCRINE

	Y	N
Diabetes		
Thyroid disease		
Taking steroids		
Other		

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RESPIRATORY

	Y	N
Seasonal allergies		
Sinus trouble		
Asthma		
What is asthma induced by?		
Is an inhaler used?		
Emphysema		
Bronchitis		
COPD		
Tuberculosis		
Breathing difficulties		
Other		

MUSCULOSKELETAL

	Y	N
Arthritis		
Joint replacement		
When?		
Complications?		
Physician's name		
Bone disorder		
Muscle disorder		
Other		

If you have any disease, condition, or problem not listed that you think I should know about, please explain below:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

____ _______________

FOR COMPLETION BY DENTIST

Blood Pressure:__________________ Pulse:___________

ASA Classification: _____