PATIENT INFORMATION

Name: _____ Date of Birth: _____ Preferred Name: _____ Sex: M ☐ F ☐
LAST FIRST MIDDLE INITIAL

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

Home Phone:(_____) _____ Cell Phone:(_____) _____

Drivers License # _____ Email: _____

Can we contact you:(Check all that apply) Home Phone ☐, Cell Phone ☐, Work Phone ☐, Email ☐, Text message☐

Do you have a preferred time for dental appointments? _____ Are you available for last minute schedule changes? Yes☐ No ☐

Employer: _____ Occupation: _____ Work Phone:(_____) _____ Ext: _____

Spouse's Name: _____ Phone Number (_____) _____

Insurance Holder's Name: _____ Insurance Company: _____ Employer: _____
LAST FIRST MI

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Insurance Holder's Date of Birth: _____ Ins ID#: _____ Group Number: _____

Do you have a secondary insurance? _____

Emergency Contact: _____ Relationship: _____ Phone:(_____) _____

Whom may we thank for referring you to our office? _____

What are your favorite sports/hobbies? _____ Anything other interesting facts you'd like to share ☺? _____

For the following questions, please (x) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there will be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

DENTAL INFORMATION

Yes	No	Unsure	
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets, or pressure?
☐	☐	☐	Do you get frequent cold sores or canker sores?
☐	☐	☐	Do you have areas in your mouth where food collects?
☐	☐	☐	Do you have a dry mouth?
☐	☐	☐	Do you gag easily?
☐	☐	☐	Do you usually have a lot of cavities at dental visits?
☐	☐	☐	Does it hurt to keep your mouth open for too long?
☐	☐	☐	Do you get pain in your jaw joint?
☐	☐	☐	Do you clench your teeth during the day or while sleeping?
☐	☐	☐	Have you been told that you grind your teeth in your sleep?
☐	☐	☐	Have you ever had deep cleanings / gum treatments?
☐	☐	☐	Have you ever had gum surgery?
☐	☐	☐	Have you had orthodontic treatment (braces)?
☐	☐	☐	Have you had your wisdom teeth removed?
☐	☐	☐	Have you ever had abnormal bleeding from an extraction?
☐	☐	☐	Have you ever whitened your teeth?
			Method used _____
☐	☐	☐	Do you wear a removable orthodontic retainer or bite splint?
☐	☐	☐	Do you wear a denture or partial? How many years?_____
			Would you like to make it fit better? (circle one) Yes / No
☐	☐	☐	Do you want to save your teeth versus dentures or partials?
☐	☐	☐	Have you ever had trauma or injury to your teeth?
			If yes, explain _____

_____

_____

_____

Yes	No	Unsure	
☐	☐	☐	Have you had a negative dental experience in the past?

If yes, please explain:

_____

_____

_____

In the past, I have had my teeth cleaned every:

(Circle one) 3 months / 6 months / yearly / not regularly

How often do you brush your teeth? Do they bleed? Yes / No

How often do you floss your teeth? Do they bleed? Yes / No

How would you describe your current dental condition? _____

_____

Date of your last dental visit? _____

What was done at that time? _____

Do you want anything changed about the appearance of your teeth? ____

_____

So that we can serve you better, do you have any expectations of us?

_____

_____

_____

_____

WOMEN ONLY

Yes	No	Unsure	
☐	☐	☐	Are you or could you be pregnant?
☐	☐	☐	Nursing?
☐	☐	☐	Taking birth control pills or hormonal replacement?

******************PLEASE COMPLETE BOTH SIDES******************

MEDICAL INFORMATION

Yes No Unsure

☐ ☐ ☐ Have you had any serious illness, operations or have you been hospitalized in the last 5 years?
If yes, please explain:_____

_____

☐ ☐ ☐ Are you now under the care of a physician?
If yes, What is/are the condition(s) being treated?

_____

_____

Date of last Physical examination:_____

Physician:_____ _____
NAME PHONE

_____ _____ _____
ADDRESS CITY/STATE ZIP

☐ ☐ ☐ Do you currently take any Prescription Medications?
If yes, please list: _____

_____

_____

_____

_____

_____

_____

_____

☐ ☐ ☐ Do you currently take any Over the Counter Medications?
If yes, please list?_____

_____

_____

☐ ☐ ☐ Do you currently take any Herbal Medications or Dietary Supplements?

_____

_____

_____

Please (X) response to indicate if you have had any of the following:

Yes No Unsure

☐ ☐ ☐ Abnormal bleeding from a cut or surgery

☐ ☐ ☐ AIDS / HIV or immunocompromised

☐ ☐ ☐ Alcohol dependency

☐ ☐ ☐ Allergies (check all that apply)

____Latex, if yes, inhalation or contact
____Local anesthetics ____Iodine
____Penicillin ____Amoxicillin
____Clindamycin ____other antibiotics
____Codeine or other narcotics
____Metals (can you wear inexpensive jewelry?)

Food (specify)_____
Other (specify)_____
To checked allergies, specify type of reactions:_____
_____

Yes No Unsure

☐ ☐ ☐ Anemia

☐ ☐ ☐ Asthma
Have you been hospitalized for it? Yes / No
Do you carry an inhaler? Yes / No

☐ ☐ ☐ Cardiovascular disease (check all that apply)

____Angina ____Heart surgery
____Arrhythmia ____High blood pressure
____Artificial valve ____Bacterial endocarditis
____Congenital heart defects ____Pacemaker
____Congestive heart failure ____Heart attack

☐ ☐ ☐ Cancer Type:_____ Location:_____

☐ ☐ ☐ Radiation treatment of head or neck?

☐ ☐ ☐ Chest pain upon exertion

☐ ☐ ☐ Use Tobacco (smoking, snuff, chew)
If yes, how interested are you in stopping?
(Circle one) Very / Somewhat / Not Interested

☐ ☐ ☐ Currently using cocaine

☐ ☐ ☐ Diabetes ____insulin dependent
____ non-insulin dependent

☐ ☐ ☐ Eating disorders (specify): _____

☐ ☐ ☐ G. E. Reflux / persistent heart burn (GERD)

☐ ☐ ☐ Hearing problems

☐ ☐ ☐ Hemophilia

☐ ☐ ☐ Hepatitis / liver disease If yes, type A, B or C_____

☐ ☐ ☐ Mental disorders (specify)_____

☐ ☐ ☐ Orthopedic joint replacement (knee, hip)
Date of operation:_____
Any complications? _____

☐ ☐ ☐ Osteoporosis therapy or high blood calcium therapy due to cancer? If yes, have you ever used:

___ Fosomax/alendronate ___ Boniva/ ibandronate
___ Actonel/ risedronate ___ Aredia/ pamidronate
___ Didronel/etidronate ___ Zometa/ zoledronate
___ Reclast/ zoledronic acid ___ Bonefos/ clodronate
___ Skelid/ tiludronate ___ Aclasta/ zoledronate

☐ ☐ ☐ Severe headaches / migraines

☐ ☐ ☐ Sexually transmitted disease

☐ ☐ ☐ Stroke

☐ ☐ ☐ Tuberculosis

Do you have any disease, condition or problem, not listed above, that you think our dentist should know about?

Please explain:_____
_____
_____
_____

I certify that I have read and understand the above. 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 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 completion of this form.
I hereby authorize and direct payment of the dental payments otherwise payable to me, directly to Dental Perfections, SC.

_____
SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE SIGNATURE OF DENTIST

Patient Initials:_____ Date:_____ Comments:_____
Patient Initials:_____ Date:_____ Comments:_____
Patient Initials:_____ Date:_____ Comments:_____
Patient Initials:_____ Date:_____ Comments:_____
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