Print Form

FAMILY CARE DENTISTRY

PATIENT INFORMATION

We appreciate the confidence you have placed in us to provide dental care to you. All information on this chart is necessary for our records and are strictly confidential.

Date: **Name:**			
Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Social Security #:**	
Employer:	**Work Phone:**	**Date of Birth:**	
Email Address:			
Emergency Contact:	**Primary Phone:**		

POLICY HOLDER INFORMATION

Name:	**Social Security:**	**Date of Birth:**
Insurance Company:	**Insurance Policy #:**	**Insurance Group #:**

PERSON FINANCIALLY RESPONSIBLE FOR THE ACCOUNT (IF DIFFERENT THE POLICY HOLDER)

Name: **Primary Phone:**

How did you hear about our office? ☐ Radio ☐ TV ☐ Advertisement ☐ Visual ☐ Other ☐ Current Patient Referral:

DENTAL HEALTH INFORMATION

Please Check Yes or No

Are you having any discomfort?	**Yes** ☐ **No** ☐	Any sensitivity to hot, cold, sweets and/or chewing?	**Yes** ☐ **No** ☐
Do you smoke or use tobacco?	**Yes** ☐ **No** ☐	Does dental treatment make you nervous?	**Yes** ☐ **No** ☐
Do you drink tea or coffee?	**Yes** ☐ **No** ☐	Is the brightness of your teeth important to you?	**Yes** ☐ **No** ☐
Do you prefer to save your teeth?	**Yes** ☐ **No** ☐	Do you take a fluoride supplement?	**Yes** ☐ **No** ☐

Have you experienced any of the following?		**If I could change my smile I would make my teeth:**	
Bleeding Gums	**Yes** ☐ **No** ☐	Whiter	**Yes** ☐ **No** ☐
Bad Breath	**Yes** ☐ **No** ☐	Straighter	**Yes** ☐ **No** ☐
Soreness in jaw joint	**Yes** ☐ **No** ☐	Close Space	**Yes** ☐ **No** ☐
Grinding of teeth	**Yes** ☐ **No** ☐	Replace silver colored restorations	**Yes** ☐ **No** ☐
Snoring	**Yes** ☐ **No** ☐	Repair chipped teeth	**Yes** ☐ **No** ☐
Date of last cleaning:		Less Gum Showing	**Yes** ☐ **No** ☐
Date of last oral cancer screening:		Replace old crowns that don't match	**Yes** ☐ **No** ☐

What is the most important thing to you about your dental visit today?

What is the most important thing to you about your future smile and dental health?

FAMILY CARE DENTISTRY

Medical History

PATIENT NAME: **DATE OF BIRTH:**

Although dental personnel treat the area in and around the mouth, your mouth is part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Are you under a physicians care now? ☐ **Yes** ☐ **No**
If yes, please explain.

Have you ever been hospitalized or had a major operation? ☐ **Yes** ☐ **No**
If yes, please explain.

Have you ever has a serious head or neck injury? ☐ **Yes** ☐ **No**
If yes, please explain.

Are you taking and medication, pills or drugs? ☐ **Yes** ☐ **No**
If yes, please explain.

Are you allergic to any of the following? ☐ **Aspirin** ☐ **Penicillin** ☐ **Codeine** ☐ **Local Anesthetics** ☐ **Acrylic** ☐ **Metal** ☐ **Latex** ☐ **Other** **If yes, please explain**

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes ☐ No ☐	Cortisone Medication	Yes ☐ No ☐	**Hemophilia**	Yes ☐ No ☐	**Radiation Treatments**	Yes ☐ No ☐
Alzheimer's Disease	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	**Hepatitis A**	Yes ☐ No ☐	**Recent Weight Loss**	Yes ☐ No ☐
Anaphylaxis	Yes ☐ No ☐	Drug Addiction	Yes ☐ No ☐	**Hepatitis B Or C**	Yes ☐ No ☐	**Renal Dialysis**	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Easily Winded	Yes ☐ No ☐	**Herpes**	Yes ☐ No ☐	**Rheumatic Fever**	Yes ☐ No ☐
Angina	Yes ☐ No ☐	Emphysema	Yes ☐ No ☐	**High Blood Pressures**	Yes ☐ No ☐	**Rheumatism**	Yes ☐ No ☐
Arthritis/Gout	Yes ☐ No ☐	Epilepsy or Seizures	Yes ☐ No ☐	**High Cholesterol**	Yes ☐ No ☐	**Scarlet Fever**	Yes ☐ No ☐
Artificial Heart Valve	Yes ☐ No ☐	Excessive Bleeding	Yes ☐ No ☐	**Hives or Rash**	Yes ☐ No ☐	**Shingles**	Yes ☐ No ☐
Artificial Joint	Yes ☐ No ☐	Excessive Thirst	Yes ☐ No ☐	**Hypoglycemia**	Yes ☐ No ☐	**Sickle Cell Disease**	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Fainting Spells/Dizziness	Yes ☐ No ☐	**Irregular Heartbeat**	Yes ☐ No ☐	**Sinus Trouble**	Yes ☐ No ☐
Blood Disease	Yes ☐ No ☐	Frequent Cough	Yes ☐ No ☐	**Kidney Problems**	Yes ☐ No ☐	**Spina Bifida**	Yes ☐ No ☐
Blood Transfusion	Yes ☐ No ☐	Frequent Diarrhea	Yes ☐ No ☐	**Leukemia**	Yes ☐ No ☐	**Stomach/Intesttinal Disease**	Yes ☐ No ☐
Breathing Problem	Yes ☐ No ☐	Frequent Headaches	Yes ☐ No ☐	**Liver Disease**	Yes ☐ No ☐	**Stroke**	Yes ☐ No ☐
Bruise Easily	Yes ☐ No ☐	Genital Herpes	Yes ☐ No ☐	**Low Blood Pressure**	Yes ☐ No ☐	**Swelling of Limbs**	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐	**Lung Disease**	Yes ☐ No ☐	**Thyroid Disease**	Yes ☐ No ☐
Chemotherapy	Yes ☐ No ☐	Hay Fever	Yes ☐ No ☐	**Mitral Valves Prolapse**	Yes ☐ No ☐	**Tonsillitis**	Yes ☐ No ☐
Chest Pains	Yes ☐ No ☐	Heart Attack/Failure	Yes ☐ No ☐	**Osteoporosis**	Yes ☐ No ☐	**Tuberculosis**	Yes ☐ No ☐
Cold Sores/Fever Blisters	Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐	**Pain in Jaw Joints**	Yes ☐ No ☐	**Tumors or Growths**	Yes ☐ No ☐
Congenital Heart Disorder	Yes ☐ No ☐	Heart Pacemaker	Yes ☐ No ☐	**Parathyroid Disease**	Yes ☐ No ☐	**Venereal Disease**	Yes ☐ No ☐
Convulsions	Yes ☐ No ☐	Heart Trouble Disease	Yes ☐ No ☐	**Psychiatric Care**	Yes ☐ No ☐	**Yellow Jaundice**	Yes ☐ No ☐

Have you had any other serious illness not listed above?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN **DATE:**