Comprehensive Patient Information and Medical History

***As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential, subject to applicable laws.*

PATIENT INFORMATION

First Name *:_____Last Name *:_____

Date of Birth*:_____Gender*:_____SSN*:_____

Primary Phone Number*:_____Email Address*:_____

Address*:_____

Address line 2 (Optional)_____

City *:_____State *:_____Zip *:_____

EMERGENCY CONTACT INFORMATION:

1. Full Name:_____Phone Number:_____

2. Full Name:_____Phone Number:_____

REFERRAL SOURCE:

How did you hear about our office *?

[__] Patient
[__] Mailers
[__] Drive By
[__] Flyers
[__] Staff Referral
[__] Walk-in
[__] Provider/Practice
[__] Internet/Google
[__] Community Outreach
[__] Family/Friend Non-Patient
[__] Social Media
[__] Veteran's Affairs
[__] Radio
[__] Other

If applicable, provide the name of whom we can thank:_____

DENTAL INFORMATION

DENTAL HEALTH:

PLEASE SELECT YES OR NO TO THE FOLLOWING DENTAL HEALTH QUESTIONS:

Do you have any immediate dental concerns *? **YES / NO**

If YES, please explain:_____

Are you currently experiencing dental pain or discomfort *? **YES / NO**

If YES, please explain:_____

Have you had any problems with previous dental treatment *? **YES / NO**

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Have you ever had a serious injury to your head or mouth *? **YES / NO**
Do your gums bleed when you brush or floss *? **YES / NO**
Have you ever had teeth become loose, without injury *? **YES / NO**
Have you had any periodontal (gum) treatments *? **YES / NO**
Have you had any cavities in the last 3 years *? **YES / NO**
Are your teeth sensitive to cold, hot, sweets or pressure *? **YES / NO**
Do you ever have times your mouth feels dry *? **YES / NO**
Do you brux, grind, or clinch your teeth *? **YES / NO**
Do you have earaches or neck pain? **YES / NO**
Do you have any clicking, popping or discomfort in the jaw *? **YES / NO**
Have your teeth become shorter, thinner, or worn in the last 5 yrs*? **YES / NO**
Have you ever had a sleep test *? **YES / NO**
Have you ever had orthodontic (braces) treatment *? **YES / NO**
Do you have sores or ulcers in your mouth *? **YES / NO**
Do you wear dentures or partials *? **YES / NO**
Is there anything you would like to change about your smile *? **YES / NO**

If YES, please explain:_____

DENTAL HISTORY:

Date of your last dental exam *?

[__] 0 - 6 months ago [__] 6 months - 1 year ago [__] 1 or more years ago

Date of your last dental x-rays *?

[__] 0 - 6 months ago [__] 6 months - 1 year ago [__] 1 or more years ago

PREVIOUS OR OTHER DENTAL PROVIDER INFORMATION:

Complete the following if you are a new patient or have regular visits with another dental provider.

Dental Provider or Practice Name:_____

Dental Provider or Practice Phone Number:_____

MEDICAL INFORMATION

Do you use tobacco (smoking, snuff, chew, vaping) *? **YES / NO**
Do you consume alcohol or use recreational drugs *? **YES / NO**
Have you had a serious illness, operation or hospitalization in the past 5 years *? **YES / NO**
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment *? **YES / NO**
Are you currently under the care of a physician *? **YES / NO**

If YES, please explain:_____

If you are currently under the care of a physician, please complete the "Physician Information" section.

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PHYSICIAN INFORMATION:

Physician Name:_____Physician Phone Number:_____

Date of last visit:_____

Did you have bloodwork completed as part of your last visit? **YES / NO**

HABITS:

PLEASE MARK YES OR NO IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

Thumb/finger sucking * **YES / NO**

Tongue Thrust * **YES / NO**

Lip sucking/biting * **YES / NO**

Speech problems * **YES / NO**

Mouth breather * **YES / NO**

Nail biting * **YES / NO**

MEDICATION:

Are you prescribed blood thinners *? (Aspirin, Heparin, Warfarin, etc.) **YES / NO**

Have you taken medications containing bisphosphonates *? **YES / NO**

Are you currently taking any GLP-1 medications for weight loss *? **YES / NO**

Are you taking any prescription or over the counter medication(s) *? **YES / NO**

Please list all prescribed or over the counter medication(s):

Medication:_____

_____

ALLERGIES:

PLEASE MARK YES OR NO IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

Anesthesia * **YES / NO**

Aspirin * **YES / NO**

Barbiturates/sedatives/sleeping pills * **YES / NO**

If YES, please explain:_____

Codeine or other narcotics * **YES / NO**

Sulfa drugs * **YES / NO**

Tetracycline/Erythromycin/Penicillin/Other antibiotics * **YES / NO**

If YES, please explain:_____

Jewelry/Metals * **YES / NO**

Latex (rubber) * **YES / NO**

Hay fever/ Seasonal * **YES / NO**

Do you have any allergies not listed above *? **YES / NO**

Please list any allergies not listed above:

Allergies:_____

_____

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WOMEN ONLY Are you:

Pregnant/Nursing? **YES / NO**

If YES, please explain:_____

Taking birth control pills or hormonal replacement? **YES / NO**

JOINT REPLACEMENT/IMPLANT:

Have you ever undergone a total orthopedic joint replacement or had any orthopedic implants placed in your body *? **YES / NO**

If YES, please explain:_____

Date Of Replacement or Implant:_____

HEART CONDITIONS:

PLEASE MARK YES OR NO IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

Artificial (prosthetic) heart valve * **YES / NO**

Congenital heart disease (CHD) * **YES / NO**

Cardiovascular disease * **YES / NO**

Chest pain / Angina * **YES / NO**

Arteriosclerosis / Coronary artery disease * **YES / NO**

Congestive heart failure * **YES / NO**

Heart attack * **YES / NO**

Heart murmur * **YES / NO**

Low blood pressure * **YES / NO**

High blood pressure * **YES / NO**

Mitral valve prolapse * **YES / NO**

Pacemaker * **YES / NO**

Cardiac stent * **YES / NO**

History of Endocarditis * **YES / NO**

MEDICAL CONDITIONS, DISEASES, AND PROBLEMS:

PLEASE MARK YES OR NO IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

Hemophilia / Abnormal bleeding * **YES / NO**

Blood transfusion * **YES / NO**

Anemia * **YES / NO**

Autoimmune disease(e.g., rheumatoid arthritis, lupus, scleroderma)* **YES / NO**

If YES, please explain:_____

HIV + / AIDS * **YES / NO**

Arthritis / Pain in joints * **YES / NO**

Asthma / Breathing problems * **YES / NO**

Tuberculosis * **YES / NO**

Emphysema / Bronchitis / Persistent cough * **YES / NO**

Sinus trouble * **YES / NO**

Rheumatic fever * **YES / NO**

Hearing or Vision Impairment * **YES / NO**

If YES, please explain:_____

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Cancer / Chemotherapy / Radiation *	**YES / NO**
If YES, please explain: _____	
Chronic pain *	**YES / NO**
If YES, please explain: _____	
Diabetes *	**YES / NO**
Glaucoma *	**YES / NO**
Hepatitis / Jaundice / Liver disease *	**YES / NO**
If YES, please explain: _____	
Mental Health Conditions (e.g., anxiety, depression, bipolar) *	**YES / NO**
If YES, please explain: _____	
Neurological disorders *	**YES / NO**
If YES, please explain: _____	
Snoring *	**YES / NO**
Sleep disorder *	**YES / NO**
Severe / Rapid weight loss *	**YES / NO**
Eating disorder / Malnutrition *	**YES / NO**
Gastrointestinal disease *	**YES / NO**
Reflux / Persistent heartburn *	**YES / NO**
Sores / Ulcers in the mouth *	**YES / NO**
Thyroid problems *	**YES / NO**
Stroke *	**YES / NO**
Epilepsy / Seizures *	**YES / NO**
Dizziness / Fainting *	**YES / NO**
Recurrent Infections *	**YES / NO**
Kidney problems *	**YES / NO**
Night sweats *	**YES / NO**
Osteoporosis *	**YES / NO**
Persistent swollen glands in neck *	**YES / NO**
Frequent / Severe headaches *	**YES / NO**
Sexually transmitted infection *	**YES / NO**
Difficulty urinating / Prostate *	**YES / NO**
Do you have any other diseases, or conditions, problems *?	**YES / NO**

Please list any other diseases, conditions, problems, or accommodation not listed above.

Diseases, Conditions, Problems: _____

SIGNATURE

***I certify that 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 patients') health. I acknowledge that It is my responsibility to inform the dental team of any changes in medical status and I will not hold my doctor, affiliated entities, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.*

Date *: _____ Signature *: _____