CompleteDentistry

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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.

First Name: _____ M.I. ____ Last Name: _____ Birthdate: _____

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

Home Phone: _____ Cell Phone: _____ Work: _____

SS# _____ Email: _____

(Circle one)
Preferred Contact: Cell Work Home Email Preferred Confirmation Method: Email Text Phone

Gender: Male Female Marital Status: Married Single Divorced Widowed Separated

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

RESPONSIBLE PARTY INFORMATION

Name: _____

Employer: _____

SS# _____

EMERGENCY INFORMATION

Name: _____

Phone: _____

Relation to Patient: _____

DENTAL INSURANCE INFORMATION

Insured's Name: _____

Insurance Company: _____

Address: _____

Insured's Employer: _____

Insured's SS# _____

Group # _____

Insured's Date of Birth: _____

SECONDARY INSURANCE

Insured's Name: _____

Insurance Company: _____

Address: _____

Insured's Employer: _____

Insured's SS# _____

Group # _____

Insured's Date of Birth: _____

CONFIRMATION

I certify 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 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 (or parent)_____ **Date:** _____

MEDICAL INFORMATION- Do you have or have you had any of the following?

☐ Heart problems or disease	☐ Kidney problems	☐ Artificial joint/hip replacement
☐ High blood pressure	☐ Congenital Heart disorder	☐ Artificial heart valve
☐ Pacemaker	☐ Heart Attack/Heart failure	☐ Anxiety/panic disorder
☐ Circulatory problems	☐ Mitral valve prolapse	☐ Psychiatric care
☐ Stroke	☐ Asthma	☐ Hepatitis A,B or C
☐ Heart murmur	☐ Sinus problems	☐ Drug/alcohol addiction
☐ Rheumatic fever	☐ Sleep apnea	☐ Epilepsy or seizures
☐ Anemia/bleeding disorder	☐ Headaches-frequent or severe	☐ Ulcer
☐ Malignancy (cancer)	☐ Arthritis	☐ Diabetes
☐ Radiation therapy	☐ Aids/HIV positive	☐ Premedication required?

Do you have any disease, condition or problem not listed above that you think we should know about? Please explain:

_____

Are you allergic to or have you had a reaction to:

☐Local anesthetics	☐Latex (rubber)	☐ Penicillin or other antibiotics
☐Sulfa drugs	☐ Food	☐Hay fever/seasonal
☐Codeine/other narcotics	☐ Metals	☐ Acetaminophen
☐Other: _____	☐ Aspirin	☐ Ibuprofen

Please list all medications you are currently taking:

_____

During the past twelve months, have you taken any of the following?

☐Antibiotics	☐Coumadin	☐ High Blood Pressure medicine	☐Cortisone (steroids)
☐Sulfa drugs	☐Warfarin	☐ Insulin, Orinase or Similar drug	☐ Natural remedies
☐Anticoagulants	☐Plavix	☐ Controlled substances	☐ Aspirin
☐Nitroglycerin	☐ Digitalis	☐ Ibuprofen	☐ Fosamax

For Women: Are you pregnant? ☐Yes ☐No How many weeks? _____ Are you nursing? ☐Yes ☐No
Taking birth control pills or hormone replacement? ☐Yes ☐No

Physician Name:_____ Phone: _____Date of last physical _____

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

DENTAL INFORMATION

When was your last dental visit? _____ Were X-rays taken? ☐Yes ☐No
Name of previous dentist: _____Phone: _____
What is your primary concern? _____

Have you ever had trouble getting numb or had reactions to local anesthetic?	☐Yes	☐No
Do your gums bleed, or feel tender or irritated?	☐Yes	☐No
Have you ever had any periodontal (gum) treatments	☐Yes	☐No
Do you have cold sores or ulcers in your mouth?	☐Yes	☐No
Does food collect between your teeth?	☐Yes	☐No
Do you have any clicking, popping or discomfort in the jaw?	☐Yes	☐No
Do you clench or grind your teeth frequently?	☐Yes	☐No
Are your teeth sensitive to: hot, cold, sweets?	☐Yes	☐No
Are you satisfied with the appearance of your teeth?	☐Yes	☐No
Have you ever had a serious injury to your head or mouth?	☐Yes	☐No
Do you use tobacco (smoking, snuff, chew)?	☐Yes	☐No
Have you had any problems associated with previous dental treatment?	☐Yes	☐No
Have you had orthodontic (braces) treatment?	☐Yes	☐No