PATIENT INFORMATION

PATIENT'S NAME _____ DATE OF BIRTH mm/dd/yyyy SS# _____

ADDRESS _____ CITY _____ STATE _____ ZIPCODE _____

CELL #_____ HOME #_____ WORK #_____ DRIVER'S LICENSE # _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

If patient is under 18yrs of age:

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

PATIENT MEDICAL HISTORY

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A 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 THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1. ARE YOU IN GOOD HEALTH.....	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH.....	☐	☐
3. PHYSICIAN'S NAME_____		
4. HAVE YOU EVER HAD ANY MAJOR SURGICAL OPERATION OR JOINT REPLACEMENT..... PLEASE LIST & WHEN_____	☐	☐
5. DO YOU BRUISE EASILY.....	☐	☐
6. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION.....	☐	☐
7. DO YOU HAVE A COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS).....	☐	☐
8. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES.....	☐	☐
9. DO YOU USE TOBACCO.....	☐	☐
10. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED THAT YOU THINK I SHOULD KNOW ABOUT_____		
11. PLEASE LIST ANY MEDICATIONS & NON-PRESCRIPTION MEDICINE YOU ARE TAKING _____ _____		

WOMEN ONLY

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT..... ☐

ARE YOU NURSING..... ☐

ARE YOU TAKING BIRTH CONTROL PILLS..... ☐

CHECK ONLY IF YOU HAVE A HISTORY OF, OR CONDITIONS RELATED TO ANY OF THE FOLLOWING:

HEART TROUBLE/ATTACK, OR ANGINA.... ☐	LUNG/BREATHING PROBLEMS... ☐	CHEMOTHERAPY(cancer/tumors).... ☐
HEART SURGERY..... ☐	ASTHMA..... ☐	CHEMICAL DEPENDENCY..... ☐
PACEMAKER..... ☐	SINUS TROUBLE..... ☐	ANEMIA(IRON DEFICIENCY)..... ☐
STROKE..... ☐	KIDNEYS..... ☐	COLD SORES/FEVER BLISTERS..... ☐
HIGH/LOW BLOOD PRESSURE..... ☐	DIABETES..... ☐	TONSILLITIS..... ☐
BLOOD..... ☐	HEARTBURN/ACID REFLUX..... ☐	MENTAL HEALTH CARE..... ☐
THYROID..... ☐	EPILEPSY/SEIZURES..... ☐	EATING DISORDER..... ☐
LIVER/HEPATITIS/JAUNDICE..... ☐	TUBERCULOSIS..... ☐	SNORING..... ☐
AIDS OR HIV INFECTION..... ☐	ABNORMAL BLEEDING..... ☐	SLEEP APNEA..... ☐
SEXUALLY TRANSMITTED DISEASE..... ☐	ARTHRITIS/RHEUMATISM..... ☐	CORTISONE TREATMENT..... ☐

CHECK ONLY IF YOU ARE ALLERGIC TO OR HAVE HAD REACTIONS/PROBLEMS WITH THE FOLLOWING:

LOCAL ANESTHETICS (NOVOCAINE)..... ☐	ASPIRIN..... ☐	OTHER (PLEASE LIST):
PENICILLIN OR OTHER ANTIBIOTICS..... ☐	IODINE..... ☐	_____
SULFA DRUGS..... ☐	METALS(nickel,mercury,etc.).... ☐	_____
BARBITURATES..... ☐	LATEX/RUBBER..... ☐	
SEDATIVES OR SLEEPING PILLS..... ☐	SEASONAL..... ☐	

PATIENT DENTAL HISTORY

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL HYGIENE VISIT _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

DO YOU USE A TOOTHPASTE OR MOUTH RINSE WITH FLUORIDE _____

WHAT IS YOUR MAIN SOURCE OF DRINKING WATER ☐ CITY ☐ WELL ☐ BOTTLED ☐ FILTERED

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING……..	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS…….	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS……...	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH...	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH……..	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES……..	☐	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW:		
CLICKING…….	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE)……..	☐	☐
DIFFICULTY IN OPENING OR CLOSING……	☐	☐
DIFFICULTY IN CHEWING……	☐	☐
8. DO YOU HAVE FREQUENT HEADACHES…….	☐	☐

	YES	NO
9. DO YOU CLENCH OR GRIND YOUR TEETH…...	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY……...	☐	☐
11. HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH…….	☐	☐
12. DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH…….	☐	☐
13. HAVE YOU EVER HAD PERIODONTAL (GUMS) TREATMENT……..	☐	☐
14. HAVE YOU EVER WORN A SPLINT OR NIGHT GUARD……...	☐	☐
15. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST, INCLUDING PROLONGED BLEEDING…….	☐	☐
16. DO YOU WEAR DENTURES OR PARTIALS……. IF YES, DATE OF PLACEMENT mm/dd/yyyy	☐	☐
17. DO YOU HAVE PROBLEMS WITH NERVOUSNESS OR ANXIETY WITH DENTAL APPOINTMENTS…	☐	☐

DOCTOR'S COMMENTS _____

_____

_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I acknowledge I have been provided with and have reviewed a copy of First City Dental's privacy, security, and breach notification policies and procedures. I understand that I should ask the privacy officer if I have any questions about these policies and procedures. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ DATE _____

Patient Signature or Parent/Guardian if a minor

Hygienist Initials _____ Date _____ Doctor Initials _____ Date _____

REGISTRATION / HEALTH HISTORY