INGLESIDE FAMILY DENTAL

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date:_____ Sex:_____ Age:_____

Home address: _____ City:_____ State:_____ Zip:_____

Billing address (if different):_____ City:_____ State:_____ Zip:_____

Home phone: _____ Cell:_____ E-mail:_____Driver's license #:_____ State:___

SS #:_____ Employer/Occupation:_____ Bus. Phone:_____

Spouse's name & phone #: _____ Emergency phone # (other than spouse)_____

Primary dental insurance:_____ Group #:_____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth:_____ SS #:_____

Name of your medical doctor: _____ Date of last visit to medical doctor:_____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____

DENTAL HEALTH HISTORY

Are you apprehensive about dental treatment?	Yes	No
Have you had problems with previous dental treatment?	Yes	No
Do you gag easily?	Yes	No
Do you wear dentures?	Yes	No
Does food catch between your teeth?	Yes	No
Do you have difficulty in chewing your food?	Yes	No
Do you chew on only one side of your mouth?	Yes	No
Do you avoid brushing any part of your mouth because of pain?	Yes	No
Do your gums bleed easily?	Yes	No
Do your gums bleed when you floss?	Yes	No
Do your gums feel swollen or tender?	Yes	No
Have you ever noticed slow-healing sores in your mouth?	Yes	No
Are your teeth sensitive?	Yes	No
Do you feel twinges of pain when your teeth come in contact with:	Yes	No
• Hot foods or liquids?	Yes	No
• Cold foods or liquids?	Yes	No
• Sours?	Yes	No
• Sweets?	Yes	No
Do you take fluoride supplements?	Yes	No
Are you dissatisfied with the appearance of your teeth?	Yes	No
Do you prefer to save your teeth?	Yes	No
Do you want complete dental care?	Yes	No
Are you unable to open your mouth as far as you want?	Yes	No
Are you aware of an uncomfortable bite?	Yes	No
Have you had a blow to the jaw (trauma)?	Yes	No
Are you a habitual gum chewer or pipe smoker?	Yes	No

How often do you brush?_____

How often do you floss? _____

Does your jaw make noise so that it bothers you or others?	Yes	No
Do you clench or grind your jaws frequently?	Yes	No
Do your jaws ever feel tired?	Yes	No
Does your jaw get stuck so that you can't open freely?	Yes	No
Does it hurt when you chew or open wide to take a bite?	Yes	No
Do you have earaches or pain in front of the ears?	Yes	No
Do you have any jaw symptoms or headaches upon awaking in the morning?	Yes	No
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	Yes	No
Do you find jaw pain or discomfort extremely frustrating or depressing?	Yes	No
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepresssants)?	Yes	No
Do you have a temporomandibular (jaw) disorder (TMD)?	Yes	No
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	Yes	No
Are you unable to open your mouth as far as you want?	Yes	No

INGLESIDE FAMILY DENTAL

MEDICAL HISTORY

Patient Name _____ Birth Date:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Healthy problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now?	☐Yes	☐No	If yes:_____
Have ever been hospitalized/major operation?	☐Yes	☐No	If yes:_____
Have ever had a serious head or neck injury?	☐Yes	☐No	If yes:_____
Are you taking any medications?	☐Yes	☐No	If yes:_____
Are you on a special diet?	☐Yes	☐No	
Do you use tobacco?	☐Yes	☐No	
Do you use controlled substances?	☐Yes	☐No	If yes:_____
Do you require premedication prior to dental care?	☐Yes	☐No	If yes:_____

Women: Are you...

☐ Pregnant ☐ Nursing ☐ Trying to get pregnant ☐ Taking oral contraceptives

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other: _____

Do you have, or have you had, any of the following (Circle "Yes" or "No"):

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

Have you ever had any serious illness not listed above? Yes No If yes:_____

Do you have any artificial body parts or organs? Yes No If yes:_____

Signature of Patient/Guardian/Responsible Party: _____ **Date:**_____