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.

Patient's Name _____ Preferred Name _____

Parent/Guardian (if patient is a minor) _____

Sex: ❑ Male / ❑ Female Marital Status: S/M/D/W DOB: / / Social Security #: _____-____-_____

Driver's License #_____ Email _____

Home address _____ City _____State _____ Zip _____

Home phone _____ Work _____ Cell _____

Employer's Name/School Name _____

Emergency Contact Information _____ Phone _____

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

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Primary Dental Ins _____ Dental Ins Phone #_____ Group Number_____

Covered by secondary insurance? ❑ Yes ❑ No

Subscriber Name _____ DOB: / / Social Security #: _____-____-_____

Dental Ins Co _____ Dental Ins Phone #_____ Group Number_____

Employer Name _____ Employer Address _____

***Insurance Payment Authorization**

Signature_____

*** Authorization for TVFD to submit & collect insurance claims on behalf of policy holder**

DENTAL HISTORY

What is your reason for seeking dental care today? _____

Date of last dental visit: _____ Former dental office: _____

Have you had any complications with past dental care? ❑ Yes ❑ No Please describe: _____

Do you feel anxious or nervous about coming to the dentist? ❑ Yes ❑ No

What is it that makes you most nervous/anxious? ❑ Injection/Shot ❑ Noises ❑ Other: _____

Do your gums bleed while brushing or flossing…….❑ Yes ❑ No

Are your teeth sensitive to hot/cold/sweet liquids/foods……..❑ Yes ❑ No

Do you feel pain in any of your teeth……..…...❑ Yes ❑ No

Do you have any sores in or near your mouth……❑ Yes ❑ No

Have you had any head/neck/jaw injuries…… ❑ Yes ❑ No

Have you ever experienced any of the following problems in your jaw:

Clicking……. ❑ Yes ❑ No

Pain (joint/ear/side of face)……... ❑ Yes ❑ No

Difficulty in opening or closing…….……❑ Yes ❑ No

Difficulty in chewing…….❑ Yes ❑ No

Do you clench or grind your teeth……..❑ Yes ❑ No

Do you bite your lips or cheek often……...❑ Yes ❑ No

Does food tend to become caught between teeth……❑ Yes ❑ No

Have you ever had periodontal treatment (gums)……..…… ❑ Yes ❑ No

Have you ever had any difficult extractions in the past….……❑ Yes ❑ No

Have you ever had prolonged bleeding following extractions…❑ Yes ❑ No

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 you will receive. Thank you for answering the following questions.

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ AIDS/HIV Positive
- ❑ Alcoholism
- ❑ Allergies or hives
- ❑ Anemia or blood disorders
- ❑ Arthritis/Gout
- ❑ Artificial joint or valve
- ❑ Asthma
- ❑ Blood transfusion
- ❑ Cancer or tumor
- ❑ Diabetes
- ❑ Emotional condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Hay fever or sinus trouble
- ❑ Heart ailment? Please explain _____
- ❑ Heart Attack/failure
- ❑ Heart murmur, mitral valve prolapsed, heart defect
- ❑ Hepatitis or other liver disease ❑A ❑B ❑C
- ❑ Herpes or cold sores
- ❑ High or low blood pressure
- ❑ Kidney disease
- ❑ Migraine headaches or frequent headaches
- ❑ Neurologic condition
- ❑ Pacemaker
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Tuberculosis or other lung problems
- ❑ Chemotherapy/Radiation Treatment

Are you <u>allergic</u> to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Acrylic
- ❑ Aspirin
- ❑ Other:_____

_____

Do you smoke or use chewing tobacco? ❑ Yes ❑ No
Do you take/have you taken Phen-Fen/Redux? ❑ Yes ❑ No
Are you on a special diet? ❑ Yes ❑ No
Do you use controlled substances? ❑ Yes ❑ No
If yes, please explain

_____

Women: Are you

- ❑ Pregnant/Trying to get pregnant?
  Expected delivery date: _____
- ❑ Taking hormones?
- ❑ Taking oral contraceptives?
- ❑ Nursing?

Do you have any disease, condition, or problem not listed above? ❑ Yes ❑ No

If yes, please explain_____

Have you ever been hospitalized or had a major operation ❑ Yes ❑ No

If yes, please explain_____

Are you taking any medications, pills, or drugs? ❑ Yes ❑ No

If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❑ Yes ❑ No

If yes, please explain: _____

Name of your physician: _____

Please add anything else you would like us to know about: _____

Comments: _____

Signature of treating doctor _____ Date _____

To the best of my knowledge, the questions on the above forms 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 _____