Patient Information

DATE: _____ /____ /_____

Patient's Name ____________________

Parent's Name if Minor ____________________

Home Address ____________________

City ____________________ State ________ Zip ________

Date of Birth ____________________

E-Mail ____________________

Home phone ____________________

Cell phone ____________________

Work phone ____________________

If You Have Insurance, Name of Insured ____________________

Insured Employed by ____________________

Name of Insurance Company (please bring card to first appt.) ____________________

How Did You Learn about Our Office ____________________

Health History

Have you been hospitalized or under the care of a physician during the past 2 years? YES ☐ No ☐

If YES, please explain ____________________

ALLERGIES

Are you allergic to (i.e. itching, swelling, rash, severe reaction) or made sick by any of the following

☐ Latex ☐ Eggs ☐ Aspirin ☐ Codeine

☐ Penicillin/Amoxicillin ☐ Tylenol/Acetaminophen ☐ Darvocet/Darvon ☐ Vicodin/Hydrocodone

☐ Motrin/Ibuprofen ☐ Demerol/Meperidine ☐ Morphine ☐ Fentanyl/Sublimaze

☐ Sulfa ☐ Others ____________________

FEMALE PATIENTS

Are you, or have you ever taken medication for osteoporosis? ☐ YES ☐ NO

Fosamax (alendronate) or Actonel (risedronate)

Are you, or is there a chance that you might be pregnant? ☐ YES ☐ NO

Are you breast-feeding? ☐ YES ☐ NO

Are you taking Birth Control Medication (pill, patch, shot)? ☐ YES ☐ NO

(Antibiotics may reduce the effectiveness of some contraceptives)

REVIEW OF SYSTEMS (**Check** any conditions that you have or have had in the past)

FOR STAFF USE:

HEAD & NECK (taking medication for ☐ YES ☐ NO)

☐ Sinus Problems ☐ Cancer of the Mouth or Throat

☐ Glaucoma ☐ Radiation Therapy to the Jaws

☐ Other ☐ Temporomandibular Joint Dysfunction (TMD/TMJ)

HEART (taking medication for ☐ YES ☐ NO)

☐ Coronary Artery Disease ☐ Heart Surgery

☐ Angina ☐ Pacemaker

☐ Heart Attack ☐ Defibrillator

☐ High Blood Pressure ☐ Congestive Heart Failure

☐ High Cholesterol ☐ Congenital Heart Condition

☐ Abnormal Rhythm ☐ Infective Endocarditis

☐ Heart Transplant ☐ Shunts / Conduits

LUNGS (taking medication for ☐ YES ☐ NO)

☐ Asthma ☐ Emphysema

☐ Smoke/Smoked ☐ Tuberculosis

☐ Other

ENDOCRINE/HORMONES (taking medication for ☐ YES ☐ NO)

☐ Diabetes ☐ Thyroid Problems

☐ Steroid Therapy ☐ Other

STOMACH/KIDNEY/LIVER (taking medication for ☐ YES ☐ NO) ____________________

☐ Ulcers ☐ Liver Disease

☐ Kidney Disease ☐ Hepatitis A,B or C ____________________

☐ Alcohol Drinks__________ day/wk

BLEEDING/BLOOD (taking medication for ☐ YES ☐ NO) ____________________

☐ Blood Thinners ☐ Blood Clots in Legs or Lungs

☐ Anemia ☐ Stroke ____________________

☐ Leukemia ☐ Other

NEUROLOGIC/PSYCHOLOGIC (taking medication for ☐ YES ☐ NO) ____________________

☐ Siezure Disorder ☐ Dementia ____________________

☐ Depression ☐ Anxiety ____________________

☐ BiPolar Disorder ☐ ADD/ADHD

☐ Other Neurologic / Psychiatric Disorder

OTHER

☐ Artificial Joint ☐ Arthritis ____________________

☐ Substance Addiction ☐ Fainting Spells ____________________

☐ Cancer ☐ Chemotherapy

☐ Compromised Immune System ____________________

☐ Sleep Disorder/Snoring/Chronic Tiredness

ARE THERE ANY OTHER ASPECTS TO YOUR MEDICAL HISTORY THAT YOU FEEL WOULD BE IMPORTANT FOR US TO KNOW ABOUT? ARE YOU CURRENTLY TAKING ANY OTHER MEDICATIONS OR HERBAL SUPPLIMENTS?

____

____

Dental History

Approximate date of last exam/visit ____________________

Does dental treatment make you nervous? ☐ NO ☐ Slightly ☐ Moderately ☐ Extremely

Have you ever been treated for Periodontal Disease (gum disease, pyorrhea, trench mouth)? ☐ YES ☐ NO

Do you have or have you ever had any of the following?

MOUTH	YES	*TEETH*	YES
Bleeding, swollen or sore gums------------------------	☐	Loose teeth---------------------------------	☐
Unpleasant taste / bad breath------------------------	☐	Sensitive to hot---------------------------	☐
Burning tongue / lips------------------------------------	☐	Sensitive to cold--------------------------	☐
Frequent blisters, lips / mouth------------------------	☐	Sensitive to biting------------------------	☐
Swelling--	☐	Food impaction---------------------------	☐
Orthodontic treatment (braces) ---------------------	☐	Clenching / Grinding--------------------	☐
Clicking / Popping jaw----------------------------------	☐	Changes in bite--------------------------	☐

ALL ANSWERS TO THE PRECEEDING QUESTIONS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. IF THERE ARE ANY CHANGES TO MY HEALTH OR MEDICATIONS I WILL INFORM MEADE ZOLMAN FAMILY DENTISTRY P.C.

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Signature of Patient, Parent or Guardian Date

Reviewed with patient or their representative by Dr. ____________________ Date ___ /___ /____