EASTON DENTAL TOWN

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: _____ Preferred Name: _____
Date of birth: _____ Sex: _____ Age: _____
Parent name (if under 18): _____ Parent phone: _____
Home address: _____ City: _____ State: _____ Zip: _____
Billing address (if different): _____ City: _____ State: _____ Zip: _____
Home: _____ 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 #: _____
Name of insured: _____ Relation to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Date of birth: _____ SS #: _____
Secondary dental insurance: _____ Group #: _____
Name of insured: _____ Relation to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
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

	YES	NO
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures/partials?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or around your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

How often do you brush? _____
How often do you floss? _____

	YES	NO
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your jaws often?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon waking in the morning?	☐	☐
Does jaw pain or discomfort affect sleep, appetite, or daily activities?	☐	☐
Do you find jaw pain or discomfort frustrating or depressing?	☐	☐
Do you take medicine for pain or discomfort?	☐	☐
Do you have pain in the face, cheeks, jaw, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow/trauma to the jaw?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

MEDICAL HEALTH HISTORY:

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

YES	NO	
☐	☐	**HEART PROBLEMS**
☐	☐	Chest pain
☐	☐	Shortness of breath
☐	☐	Blood pressure problems
☐	☐	Heart murmur
☐	☐	Valve problem/MVP
☐	☐	Taking heart medication
☐	☐	Rheumatic fever
☐	☐	Pacemaker
☐	☐	Artificial heart valve
☐	☐	**BLOOD PROBLEMS**
☐	☐	Easy bruising
☐	☐	Abnormal bleeding
☐	☐	Blood disease (anemia, etc.)
☐	☐	Ever required a blood transfusion?
☐	☐	**INTESTINAL PROBLEMS**
☐	☐	Ulcers
☐	☐	Weight gain or loss
☐	☐	Constipation/Diarrhea
☐	☐	Kidney or bladder problems
☐	☐	**BONE OR JOINT PROBLEMS**
☐	☐	Arthritis
☐	☐	Back or neck pain
☐	☐	Joint replacement (e.g. hip, pins, implants)? What and when? _____
☐	☐	**Stroke (s)**
☐	☐	Fainting spells, Seizures, or Epilepsy
☐	☐	Frequent or severe headaches
☐	☐	Thyroid problems

During the past year have you taken any of the following?

YES	NO	
☐	☐	Antibiotics or sulfa drugs
☐	☐	Anticoagulants (e.g. Coumadin)
☐	☐	High blood pressure medicine
☐	☐	Insulin, or similar drug
☐	☐	Aspirin
☐	☐	Digitalis or drugs for heart trouble
☐	☐	Nitroglycerin
☐	☐	Cortisone (steroids)
☐	☐	Nonprescription drugs/supplements

Other: _____

YES	NO	
☐	☐	Cancer/Tumor Treatment? _____ _____ Date of tx: _____
☐	☐	**Diabetes**
☐	☐	Tuberculosis or other respiratory disease? If so, what? _____
☐	☐	Do you drink alcohol? If so, how often? _____
☐	☐	Do you use tobacco products? If so, what type and how much? _____
☐	☐	Hepatitis, Jaundice, or Liver Trouble? If so, explain: _____
☐	☐	Herpes or other STD
☐	☐	HIV-positive/AIDS
☐	☐	Glaucoma
☐	☐	History of head injury?
☐	☐	Epilepsy or other neurological disease?
☐	☐	Psychiatric or anxiety disorder?
☐	☐	Sleep Apnea? Do you wear a CPAP? _____ Any problems with it? _____
☐	☐	History of drug or alcohol abuse?
☐	☐	Sinus problems/Hay fever
☐	☐	Asthma
☐	☐	**Premedication required by physician? What pre-med? _____ Why taken? _____**

Are you allergic or had adverse reactions to any of the following?

YES	NO	
☐	☐	Local anesthetics
☐	☐	Penicillin or other antibiotics
☐	☐	Sulfa drugs
☐	☐	Barbiturates, sedatives, or sleeping pills
☐	☐	Aspirin, Acetaminophen, or Ibuprofen
☐	☐	Codeine, Demerol, or other narcotics
☐	☐	Reaction to metals
☐	☐	Latex or rubber dam

Other: _____

Women:

YES	NO	
☐	☐	Are you pregnant? Expected delivery date? _____
☐	☐	Are you nursing?

PLEASE LIST ALL CURRENT MEDICATIONS: _____

_____

_____

Please list current medical doctors: _____

Please list any recent surgeries, hospitalizations, or other medical conditions: _____

_____

Preferred Pharmacy: _____

Patient/Parent Signature: _____ Date: _____ Dentist Signature: _____

Updated: Patient/Parent Signature: _____ Date: _____ Dentist Signature: _____