DENTAL BY DESIGN

PATIENT INFORMATION

Date: _____
First name:_____Last name:_____
Preferred name:_____
Gender: □ F □ M Marital status:_____
Birth date:_____
Social Security#:_____
Address:_____
City:_____State:_____Zip:_____
Email:_____
Home phone: _____
Work phone:_____
Cell phone:_____
Whom may we thank for referring you to our office?
□ Google □ Yelp □ ZOOM □ Facebook
□ Other: _____ □ Friend: _____
Notify in case of emergency: _____Phone:_____

EMPLOYMENT

Patient's employer:_____
Occupation: _____
Employer address: _____
City:_____State:_____Zip:_____

INSURANCE

Insurance company:_____
Subscriber's name: _____
Relationship to patient: _____
Subscriber's birth date: _____
Subscriber's ID#:_____
Subscriber's group name: _____
Insurance group #: _____

DENTAL HISTORY

Reason for today's visit: _____
Former dentist: _____
Phone: _____
Why did you leave your last dentist?_____
Date of last dental visit: _____
Date of last x-rays: _____
How often do you brush?_____
How often do you floss?_____

(x) if you have or have had any of the following:

□ abscess in mouth
□ bleeding gums
□ clenching/grinding teeth
□ clicking/popping/pain in jaw
□ cold sores/oral lesions/growths
□ dental anxiety
□ dental appliances:_____
□ dry mouth
□ extractions
□ food collection between teeth
□ gag easily
□ loose teeth or broken fillings
□ missing teeth
□ mouth odors or bad tastes
□ nail biting
□ oral surgery :_____
□ orthodontic treatment:_____
□ periodontal treatment:_____
□ root canal
□ sensitive gums
□ sensitivity to hot/cold/sweet
□ other:_____

Are you satisfied with the appearance of your teeth? □ Yes □No
If you answered no, please explain what you would like to change:

_____

Would you like a whiter smile? □Yes □No

MEDICAL HISTORY

Are you currently under physician care? _____
If so, please explain: _____
Physician's name: _____
Phone: _____
Have you had any operations or serious illnesses? □ Yes □No
If so, please explain:_____

Women: are you pregnant?_____
If so, how many months?_____Nursing?_____
Taking birth control pills?_____
(×) if you have or have had any of the following:
□ anemia □ angina □arthritis/rheumatism

□ artificial heart valves
□ artificial joints
□ asthma
□ back problems
□ blood disease
□ blood transfusion
□ cancer/tumors
□ chemical dependency
□ chemotherapy
□ circulatory problems
□ congenital heart lesions
□ cortisone treatments
□ cough ,persistent
□ cough up blood
□ diabetes
□ Emphysema
□ epilepsy/seizures
□ fainting/ dizziness
□ glaucoma
□ headaches
□ heart murmur
□ heart problems
□hemophilia/ abnormal bleeding
□ hepatitis: type____
□ herpes
□ high blood pressure
□ HIV+/AIDS
□ jaundice
□ jaw pain
□ kidney disease
□ knee/joint replacement
□ liver disease
□ mitral valve prolapse
□ pacemaker/heart surgery
□ psychiatric care
□ radiation treatment
□ rapid weight gain or loss
□ respiratory disease
□ rheumatic/scarlet fever
□ shortness of breath
□ sinus problems
□ skin rash
□ stroke
□ swelling of feet/ankles
□ thyroid disease
□ tobacco habit
How many cigarettes/day?
_____
□ tonsillitis
□ tuberculosis
□ ulcer
□ venereal disease

Do you have or have you had any disease, condition or problem not listed above? □ Yes □ No
If so, please explain: _____
List medications you are currently taking:_____
_____
Pharmacy name:_____Telephone#:_____
Do you need antibiotic premedication prior to dental visits? □ Yes □No
If so, please list the condition:_____
List allergies to any medication or substance:
□ aspirin □ codeine □ latex □ local anesthetic □ penicillin □ sulfa
□ other: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered every question on this form completely and accurately, to the best of my knowledge. I will inform my dentist of any change in my health and/or medication.

Patient signature: _____Date: _____

*****Refer a patient to our practice and you will receive a $100.00 credit toward your next treatment. This offer cannot be combined with another offer. *****