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: ______________________________

(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. *****