Stadsklev
DENTAL

PATIENT INFORMATION

Name: _____

Date of birth: _____ ❑ Male ❑ Female

Street address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ SSN _____-_____-_____

Marital status: ❑ Single ❑ Married ❑ Widowed Name of spouse: _____

Employer: _____ Occupation: _____

Work phone: _____ Email address: _____

How did you hear about our office? _____

EMERGENCY CONTACT

Person to contact/relationship: _____ Phone: _____

PLEASE COMPLETE THIS SECTION IF YOU ARE THE PATIENT'S PARENT OR LEGAL GUARDIAN:

Name: _____ Phone: _____

Address (if different from patient): _____

INSURANCE INFORMATION (If you have dental insurance please bring your card to your appointment.)

Policy holder name (if different from above): _____ Date of birth: _____

Employer: _____ SSN: _____-_____-_____

DENTAL HISTORY

Approximate date of your last dental cleaning: _____

Do you have any specific concerns regarding your teeth or gums? _____

_____

Have you ever been treated for TMJ disorder? ❑ Yes ❑ No

DENTAL HISTORY CONT.

Do you regularly suffer from headaches? ❑ Yes ❑ No Generalized pain in teeth, or musculature of your face? ❑ Yes ❑ No

Are you happy with your smile and the appearance of your teeth? ❑ Yes ❑ No

If no, what would you change about your smile? _____

_____

MEDICAL HISTORY

Physician's name and clinic_____Approx. date of last visit:_____

Have you had any serious health problems in the last five years? ❑ Yes ❑ No

If yes, please explain. _____

(Women) Are you currently pregnant? ❑ Yes ❑ No If yes, how many months? _____

Do you use tobacco? ❑ Yes ❑ No Type_____ Quantity _____

Please list all medications, vitamins, and supplements you take: _____

_____

Have you ever taken bisphosphonates (e.g. Fosimax or Zometa)? ❑ Yes ❑ No

Please check if you are allergic to any of the following:

❑ Local anesthetic
❑ Penicillin/other antibiotics
❑ Barbiturates, sedatives, or sleeping pills
❑ Sulfa drugs
❑ Aspirin
❑ Shellfish, iodine, or red wine
❑ Codeine/other narcotics
❑ Latex sensitivity
❑ Other_____

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

❑ AIDS/HIV positive
❑ Alzheimer's disease
❑ Anaphylaxis
❑ Arthritis/Gout
❑ Artificial heart valve
❑ Artificial joint
❑ Asthma
❑ Blood disease
❑ Blood transfusion
❑ Breathing problem
❑ Bruise easily
❑ Cancer
❑ Chemotherapy
❑ Chest pain
❑ Cold sores/Fever blisters
❑ Congenital heart disease
❑ Convulsions
❑ Cortisone medicine
❑ Diabetes
❑ Drug addiction
❑ Easily winded
❑ Emphysema
❑ Epilepsy or seizures
❑ Excessive bleeding
❑ Excessive thirst
❑ Fainting spells/dizziness
❑ Frequent cough
❑ Frequent diarrhea
❑ Frequent headaches
❑ Genital herpes
❑ Glaucoma
❑ Hay fever
❑ Heart attack/failure
❑ Heart murmur
❑ Heart pace maker
❑ Heart trouble/disease
❑ Hemophilia
❑ Hepatitis A
❑ Hepatitis B or C
❑ Herpes
❑ High blood pressure
❑ Hives or rash
❑ Hypoglycemia
❑ Irregular heartbeat
❑ Kidney problems
❑ Leukemia
❑ Liver disease
❑ Low blood pressure
❑ Lung disease
❑ Mitral valve prolapse
❑ Osteoporosis
❑ Pain in jaw joints
❑ Parathyroid disease
❑ Psychiatric care
❑ Radiation treatments
❑ Recent weight loss
❑ Renal dialysis
❑ Rheumatic fever
❑ Rheumatism
❑ Scarlet fever
❑ Shingles
❑ Sickle cell anemia
❑ Sinus trouble
❑ Spina Bifida
❑ Stomach/intestinal disease
❑ Stroke
❑ Swelling of limbs
❑ Thyroid disease
❑ Tonsillitis
❑ Tumors or growths
❑ Ulcers
❑ Venereal disease
❑ Yellow Jaundice
❑ Other_____

Signature:_____ Date: _____