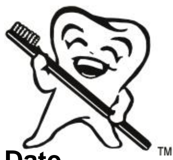

Welcome to
Dover Dental Group

PATIENT INFORMATION

Date_____________
Name____ **Home Phone** ____________________________________
Address____ **Cell Phone** ______________________________________
City____ **Work Phone**_____________________________________
State and Zip code___________________________________ **Email** ____
Birth Date____ **SSN #**____
Circle: Male Female

DENTAL HISTORY

Former Dentist____Phone_____________________________
Address____
Approximate date of last dental appointment____

Please check (√) if you have had any problems with the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping of jaw
- ☐ Grinding teeth
- ☐ Loose teeth
- ☐ Lost filling or crown
- ☐ Sensitivity to hot or cold
- ☐ Sores or growth in mouth

Have you ever had excessive or prolonged bleeding following a tooth extraction or other injury? Yes ☐ No ☐
Have you ever had trouble associated with previous dental treatment? Yes ☐ No ☐
Have you ever experienced dizziness, fainting, or reaction to the Novocaine? Yes ☐ No ☐
Are you wearing a removable dental appliance? Yes ☐ No ☐
If yes, how old is appliance? __________________________________

MEDICAL HISTORY

Physician's Name______________________________________Phone Number___________________
Date of last visit_____________Have you had any serious illness or operations? Yes ☐ No ☐
If yes, please specify____

Are you currently taking any medications? Yes ☐ No ☐
If yes, please list all medications: ____
____

Do you have any allergies to medicine? Yes ☐ No ☐
If yes, please list all allergies: ____
____

Women: Are you pregnant? Yes ☐ No ☐
If yes, how many months? ____
Nursing? Yes ☐ No ☐
Taking birth control pills? Yes ☐ No ☐

Please check (√) if you have had any of the following:

☐Aids/HIV Positive	☐Thyroid Disease	☐Rheumatic Fever	☐Tuberculosis
☐Artificial Heart Valve/Joints	☐Herpes	☐Epilepsy	☐Anemia
☐Cancer	☐Stroke	☐Pace Maker	☐Asthma
☐Diabetes	☐Heart Trouble	☐Venereal Disease	☐Sinus Problems
☐Chemical Dependent	☐High Blood Pressure	☐Persistent Cough	☐Psychiatric Treatment
☐Latex Allergy	☐Mitral Valve Prolapse	☐Low Blood Pressure	☐Other____________
☐Arthritis	☐Hepatitis	☐Heart Murmur	
☐Tobacco Habit	☐Bleeding Disorders	☐Syphilis	

How did you hear about us? Please specify ____

The information given above is accurate to the best of my knowledge. I understand this information will be used by the dentist to help determine the appropriate dental treatment. If there is any change in my medical information, I will inform the dentist.

Patient Signature (Parent or Guardian if minor) ____**Date**______________

Doctor's signature____**Date**_____________