



Welcome to The Dentist @ Hard Rd.



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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Clicking or popping of jaw |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Lost filling or crown |
| <input type="checkbox"/> Sensitivity to hot or cold | <input type="checkbox"/> 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:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Aids/HIV Positive | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Heart Valve/Joints | <input type="checkbox"/> Herpes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chemical Dependent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Low Blood Pressure | |
| <input type="checkbox"/> Other _____ | | | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Murmur | |
| <input type="checkbox"/> Tobacco Habit | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> 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** _____