New Dental Patient Information

PATIENT INFORMATION			
Name	Email	Date of Birth	Gender
Patient Address			
Phone No.			

MEDICAL HISTORY	
Name of Physician	Phone:
Physician's Address	

1. When was your last physical?_____

2. Are your immunizations up to date? Yes / No

3. Are you under the care of a physician? Yes / No

If Yes, for what reason:_____

4. Are you presently taking any medications/drugs/pills? Yes / No

If Yes, please list:_____

5. Are you allergic (or have an adverse reaction) to:

☐Penicillin ☐Codeine ☐Local Anesthetic ☐Aspirin ☐None

☐Other ☐Other Antibiotic If Other, please describe:_____

6. Are you sensitive or allergic to latex (i.e. experiencing itching, rash or wheezing after using latex gloves or handling a balloon)? Yes / No

If Yes, please explain:_____

7. Have you had any unusual or unexplained reactions during a surgical procedure? Yes / No

If Yes, please explain:_____

8. Do you have, or have you had, any of the following:

Yes / No Abnormal Blood Pressure	Yes / No Epilepsy	Yes / No Osteoporosis
Yes / No Alcohol Addiction	Yes / No Fainting Spells	Yes / No Prolonged Bleeding
Yes / No Anemia	Yes / No Glaucoma	Yes / No Prosthetic Implants
Yes / No Anorexia	Yes / No Hearing Impaired	Yes / No Psychiatric Care
Yes / No Arthritis/Rheumatism	Yes / No Heart Disease/Surgery	Yes / No Radiation Therapy
Yes / No Artificial Heart Valve	Yes / No Heart Murmur	Yes / No Removal of Spleen
Yes / No Artificial Joint	Yes / No Heart Pace Maker	Yes / No Rheumatic Fever

Yes / No Asthma
Yes / No Bulimia
Yes / No Cancer
Yes / No Chemical Dependency
Yes / No Chemotherapy
Yes / No Congenital Heart Disease
Yes / No Cortisone Medicine Yes / No Diabetes
Yes / No Recreational Drugs Yes / No Emphysema

Yes / No Hemophilia
Yes / No Hepatitis
Yes / No HIV Positive/AIDS Yes / No Kidney Problems Yes / No Learning Disability Yes / No Liver Disease
Yes / No Lung Disease
Yes / No Mitral Valve Prolapse
Yes / No Neurological Disorders
Yes / No Organ Transplant

Yes / No Rheumatic Heart Disease
Yes / No Sickle Cell Disease Yes / No Sinus Trouble
Yes / No Stroke
Yes / No Thyroid Problems
Yes / No Tuberculosis
Yes / No Tumors
Yes / No Ulcers
Yes / No Venereal Disease

9. Have you had any other serious illness, hospitalization or accidents? Yes / No

If Yes, please explain:_____

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10. Do you currently smoke or use the following tobacco products? ☐Cigarettes ☐Cigars ☐Pipe ☐Chew ☐ None

11. Have you used tobacco products in the past? Yes / No

If Yes, how long ago?:_____

12. Do you drink alcoholic beverages? Yes / No

If Yes, how much?:_____

For Women:

- **Are you pregnant?** Yes / No
- **Do you anticipate becoming pregnant?** Yes / No
- **Are you nursing?** Yes / No
- **Do you take birth control medications?** Yes / No
- **Number of pregnancies:**
- **Number of living children:**

Neighborhood Outreach Access to Health

Dental History

Date of Last Dental Visit:_____

- **Do your gums bleed while brushing or flossing?** Yes / No
- **Are your teeth sensitive to hot or cold liquids/foods?** Yes / No
- **Are your teeth sensitive to sweet or sour liquids/foods?** Yes / No
- **Do you feel pain to any of your teeth?** Yes / No
- **Do you have any sores on your lips in or near your mouth?** Yes / No
- **Have you had any head, neck or jaw injuries?** Yes / No
- **Do you have frequent headaches?** Yes / No
- **Do you clench or grind your teeth?** Yes / No
- **Do you bite your lips or cheeks frequently?** Yes / No
- **Have you ever experienced any of the following?**

  ☐ Clicking in jaw ☐ Pain (joint, ear, side of face)

  ☐ Difficulty in chewing ☐ Difficulty in opening or closing mouth

- **Have you had any orthodontic work?** Yes / No
- **Have you ever had prolonged bleeding following extractions?** Yes / No
- **Have you ever had instruction on the correct method of brushing your teeth?** Yes / No
- **Have you ever had instructions on the care of your gums?** Yes / No

Patient/Legal Guardian Signature:_____ Date:_____

Relationship:_____