HARRIS Family Dental S.C.

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name:__________ Date of birth: __________ Gender: __________Age: __________

Home address:__________ City:__________ State: __________ Zip: __________

Billing address (if different): __________ City:__________ State: __________ Zip: __________

Home phone: __________ Cell:__________E-mail: __________Driver's license #:__________ State: __________

SSN:__________Employer/Occupation: __________ Bus. Phone: __________

Spouse's name & phone #: __________Emergency phone # (other than spouse): __________

Primary dental insurance: __________Group #: __________

Secondary dental insurance: __________Group #: __________

Subscriber's name: __________Date of birth: __________SSN:__________

Name of your medical doctor: __________Date of last visit to medical doctor: __________

Name of previous dentist: __________Date of last visit to dentist:__________

Referred to us by: __________

DENTAL HEALTH HISTORY

	YES	NO
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐

	YES	NO
Do you want complete dental care?	☐	☐
How often do you brush?__________		
How often do you floss?__________		
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Does your jaw ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐ ☐	☐ ☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

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Is there anything about your smile that you'd like to change?________________________________

Have you ever whitened or bleached your teeth? ________________________________

Have you ever thought about straightening your teeth? ________________________________

MEDICAL HEALTH HISTORY

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

	YES	NO
Any recent hospitalizations	☐	☐
Any recent surgeries	☐	☐
Any allergies to medication (penicillin, sulfa)	☐	☐
Are you currently taking any blood thinners (plavix, warfarin, coumadin)	☐	☐
Emphysema or shortness of breath	☐	☐
Asthma	☐	☐
Breathing problems	☐	☐
Are you a smoker, smoked previously or use smokeless tobacco	☐	☐
Sinus problems	☐	☐
Any heart problems	☐	☐
Chest pain	☐	☐
Cardiac stents within the last 6 months	☐	☐
Heart attack within the last 6 months	☐	☐
History of a stroke	☐	☐
History of Infective Endocarditis	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
High cholesterol	☐	☐
Rheumatic fever	☐	☐
Scarlet Fever	☐	☐
High or low blood pressure	☐	☐
Anemia	☐	☐

	YES	NO
Prolonged bleeding	☐	☐
Do you bruise easily or experience frequent nosebleeds	☐	☐
Kidney Disease	☐	☐
Liver Disease or jaundice	☐	☐
Thyroid, parathyroid disease or calcium deficiency	☐	☐
Diabetes (if yes, please list most recent HbA1c)	☐	☐
Stomach ulcers or intestinal problems	☐	☐
Gastric reflex or other digestive problems	☐	☐
Arthritis	☐	☐
Artifical joints (hip, knee, etc)	☐	☐
History of taking bisphosphonates	☐	☐
Epilepsy, convulsions, seizures	☐	☐
Viral infections or cold sores	☐	☐
STDs	☐	☐
Hepatitis	☐	☐
HIV/AIDS	☐	☐
Tumors	☐	☐
Radiation therapy	☐	☐
Chemotherapy, immunosuppresion	☐	☐
Taking any medication for weight loss (fen-phen)	☐	☐
Experiencing frequent headaches	☐	☐
(Female) are you pregnant, are you taking birth control, are you breast feeding	☐	☐
(Male) do you have any prostate disorders	☐	☐

Please list all medications you are currently taking:________________________________

____

Please list any impending surgery or medical treatment that may affect your dental treatment: ________________________________

Do you require premedication by physician? ________________________________

Patient/Parent Signature: ________________________________

Date: ________________ Dentist Initial: ________