THE Dental OFFICE
JACKSON MN

Welcome!

Patient's Full Name: _____ Preferred Name: _____
First Middle Last

Employer Name: _____ Phone: _____

Gender: ○ M ○ F ○ Other Date of Birth: _____ Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

Responsible Party's Name (if different than above): _____

Emergency Contact: _____ Relationship: _____ Phone: _____

If you are completing this form for another person, what is your relationship to that person? _____

How did you hear about our clinic? ○ Drive By ○ Internet Search ○ Social Media ○ Family/Friend: _____

○ Other: _____

Primary Dental Insurance

Policy Holder: _____

Date of Birth: _____

Employer/Group Name: _____

Group Number: _____

Insurance Company: _____

Address: _____

Member ID or SSN: _____

Secondary Dental Insurance

Policy Holder: _____

Date of Birth: _____

Employer/Group Name: _____

Group Number: _____

Insurance Company: _____

Address: _____

Member ID or SSN: _____

Dental History

Date of Last Dental Visit: _____ Date of Last Cleaning: _____

How often do you brush your teeth? _____ How often do you floss? _____

Are you currently experiencing any dental pain or problems now? ○ Yes ○ No

If yes, please describe: _____

Do your gums bleed when you brush or floss?	○ Yes	○ No	Do you have earaches or neck pain?	○ Yes	○ No
Are your teeth sensitive to cold, hot, sweets or pressure?	○ Yes	○ No	Do you have any clicking, popping, or discomfort in the jaw?	○ Yes	○ No
Does food or floss catch between your teeth?	○ Yes	○ No	Do you brux or grind your teeth?	○ Yes	○ No
Is your mouth dry?	○ Yes	○ No	Do you have sores or ulcers in your mouth?	○ Yes	○ No
Have you had any periodontal (gum) treatments?	○ Yes	○ No	Do you wear dentures or partials?	○ Yes	○ No
Have you ever had orthodontic (braces) treatments?	○ Yes	○ No	Do you participate in active recreational activities?	○ Yes	○ No
Is your home water fluoridated?	○ Yes	○ No	Have you ever had a serious injury to your head or mouth?	○ Yes	○ No

○ Yes ○ No Have you ever been told to take a pre-medication prior to dental treatment?

○ Yes ○ No Have you ever whitened your teeth before? If yes, how: _____

○ Yes ○ No Are you interested in learning about whitening options available?

How do you feel about your smile? _____

_____

Medical History

O Yes O No Are you under a physicians care now? If yes, please explain:

_____

_____

O Yes O No Have you ever been hospitalized or had a major operation? If yes, please explain and list date of procedures:_____

_____

O Yes O No Have you ever had a serious head or neck injury? If yes, please explain:_____

_____

O Yes O No Are you taking any medications, pills or drugs? Are you taking any vitamins (natural or herbal) and/or diet supplements?

If yes, please list:_____

_____

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Local Anesthetics O Acrylic O Metal O Latex O Sulfa drugs O Antibiotics O Seasonal Allergies

O Other:_____

O Yes O No Have you ever taken bone loss prevention drugs such as Fosamax, Boniva, Actonel, or other similar drugs?

O Yes O No Are you on a special diet?

O Yes O No Do you use tobacco products?

O Yes O No Do you drink alcoholic beverages?

O Yes O No Do you use controlled substances?

Women: Are you pregnant O Yes O No If yes, # of weeks?_____ Taking oral contraceptives O Yes O No Nursing O Yes O No

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

Heart (Surgery, Disease, Attack)	O Yes	O No	Kidney Trouble	O Yes	O No	Hepatitis (A, B, C)_____	O Yes	O No
Chest Pain	O Yes	O No	Ulcers	O Yes	O No	Venereal Disease	O Yes	O No
Congenital Heart Disease	O Yes	O No	Diabetes	O Yes	O No	AIDS/HIV Positive	O Yes	O No
Heart Murmur	O Yes	O No	Thyroid Problems	O Yes	O No	Cold Sores/Fever Blisters	O Yes	O No
High/Low Blood Pressure	O Yes	O No	Glaucoma	O Yes	O No	Blood Transfusion	O Yes	O No
Mitral Valve Prolapse	O Yes	O No	Contact Lenses	O Yes	O No	Hemophilia	O Yes	O No
Artificial Heart Valve	O Yes	O No	Emphysema	O Yes	O No	Sickle Cell Disease	O Yes	O No
Pacemaker	O Yes	O No	Chronic Cough	O Yes	O No	Bruise Easily	O Yes	O No
Rheumatic Fever	O Yes	O No	Tuberculosis	O Yes	O No	Liver Disease/Yellow Jaundice	O Yes	O No
Arthritis/Rheumatism	O Yes	O No	Asthma	O Yes	O No	Neurological Disorders	O Yes	O No
Cortisone Medicine	O Yes	O No	Hay Fever/Allergies/Hives	O Yes	O No	Epilepsy or Seizures	O Yes	O No
Swollen Ankles	O Yes	O No	Latex Sensitivity	O Yes	O No	Fainting or Dizzy Spells	O Yes	O No
Stroke	O Yes	O No	Sinus Trouble	O Yes	O No	Nervous/Anxious	O Yes	O No
Diet (Special/Restricted)	O Yes	O No	Radiation Therapy	O Yes	O No	Psychiatric/Psychological Care	O Yes	O No
Artificial Joints (Hip, Knee, etc.)	O Yes	O No	Chemotherapy	O Yes	O No	Other:_____	O Yes	O No
Year_____			Tumors	O Yes	O No			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform The Dental Office of any changes in medical status.

Anesthetics are frequently used in dental procedures. This anesthesia may be local, inhalation, or intramuscular. Though rare, risks are associated with injections of anesthetics and may include swelling, bruising, infection, nerve damage, or unexpected reactions involving other complications, even death. My signature below indicates I am aware of these risks.

Patient/Responsible Party Signature:_____ Date:_____

Dentist Signature:_____