Welcome to Rocktown Family Dental Care

Client Information

First Name **Last Name**

Address

City **State** **Zip**

Home Phone Number **Work Phone Number**

Cell Phone Number **Email Address**

Social Security Number **Date of Birth**

Emergency Contact Name **Phone Number**

Policy Holder/Responsible Party Information

Name of Insured **Relationship to Client**

Address

City **State** **Zip**

Social Security Number **Client Insurance ID Number** **Policy Holder's Date of Birth**

Employer Name **Insurance Company** **Group or Policy Number**

Dental History

Previous Dentist Name **Reason for Leaving**

Date of last cleaning **Date of last x-rays**

Please explain the reason for your visit today: …….....

……

Dental History

□ **Y** □ **N** **Are you experiencing any discomfort?**
□ **Y** □ **N** **Do you snore?**
□ **Y** □ **N** **Do you have bleeding gums?**

□ Y □ N **Do you have bad breath?**
□ Y □ N **Do you grind your teeth?**
□ Y □ N **Do you play sports?**
□ Y □ N **Are you sensitive to hot, cold or sweets?**
□ Y □ N **Have you ever received Periodontal Therapy?**
□ Y □ N **Do you take a fluoride supplement?**
□ Y □ N **Do you use tobacco?**
□ Y □ N **Do you drink coffee or tea?**
□ Y □ N **Are you interested in having whiter/brighter teeth?**
□ Y □ N **Do you have difficulty brushing your teeth?**

How would you rate your smile on a scale from 1 to 10, with 10 being the highest? 1 2 3 4 5 6 7 8 9 10

What would you change about your smile if you could? _____

Denture/Partial Clients

□ Y □ N **Do you wear a denture or partial?**
How old is your denture or partial? _____
□ Y □ N **Does your denture or partial cause irritation?**
□ Y □ N **Are your dentures loose?**

Medical History

……
Primary Care Physician Name **Physician's Phone Number**

□ Y □ N **Are you under a physician's care?**
□ Y □ N **Have you been hospitalized or had a major operation?**
□ Y □ N **Have you ever had a serious head or neck injury?**
□ Y □ N **Women: Are you pregnant, trying to get pregnant or nursing?**

If you answered yes to any of the above questions, please explain: ……

……

Are you allergic or do you react adversely to any of the following?

□ Y □ N **Aspirin**
□ Y □ N **Acrylic**
□ Y □ N **Sulfa drugs**
□ Y □ N **Penicillin or other antibiotics**
□ Y □ N **Tetracycline**
□ Y □ N **Metal**
□ Y □ N **Barbiturates, sedatives or sleeping pills**
□ Y □ N **Codeine**
□ Y □ N **Latex**
□ Y □ N **Local anesthetics (Novacaine-like medication)**
□ Y □ N **Milk protein**

Other: ……..

Please check any conditions that you currently or previously have had:

□ **AIDS/HIV Positive** □ **Excessive thirst** □ **Parathyroid Disease**
□ **Alzheimer's Disease** □ **Fainting Spells/Dizziness** □ **Parkinson's Disease**

□ **Anaphylaxis**
□ **Anemia**
□ **Angina**
□ **Arthritis/Gout**
□ **Artificial Heart Valve***
□ **Artificial Joint***
□ **Asthma**
□ **Blood Disease**
□ **Blood Transfusion**
□ **Breathing Problem**
□ **Bruise Easily**
□ **Cancer**
□ **Chemotherapy**
□ **Chest Pains**
□ **Cold Sores/Fever Blisters**
□ **Congenital Heart Disorder**
□ **Convulsions**
□ **Cortisone Medicine**
□ **Diabetes**
□ **Drug Addiction**
□ **Easily Winded**
□ **Emphysema**
□ **Endocarditis**
□ **Epilepsy or Seizures**
□ **Excessive Bleeding**
□ **Frequent Cough**
□ **Frequent Diarrhea**
□ **Frequent Headaches**
□ **Glaucoma**
□ **Hay Fever**
□ **Heart Attack/Failure**
□ **Heart Murmur***
□ **Heart Pacemaker***
□ **Heart Trouble/Disease**
□ **Hemophilia**
□ **Hepatitis A**
□ **Hepatitis B or C**
□ **Herpes**
□ **High Blood Pressure**
□ **Hives or Rash**
□ **Hypoglycemia**
□ **Irregular Heartbeat**
□ **Kidney Problems**
□ **Leukemia**
□ **Liver Disease**
□ **Leukemia**
□ **Lung Disease**
□ **Mitral Valve Prolapse***
□ **Osteoporosis**
□ **Pain in Jaw Joints**
□ **Pins, Rods, Stints or Shunts**
□ **Psychiatric Care**
□ **Radiation Treatments**
□ **Recent Weight Loss**
□ **Renal Dialysis**
□ **Rheumatic Fever**
□ **Rheumatism**
□ **Scarlet Fever**
□ **Shingles**
□ **Sickle Cell Disease**
□ **Sinus Problem**
□ **Spina Bifida**
□ **Stomach/Intestinal Disease**
□ **Stroke**
□ **Swelling of Limbs**
□ **Thyroid Disease**
□ **Tonsillitis**
□ **Tuberculosis**
□ **Tumors or Growths**
□ **Ulcers**
□ **Venereal Disease**
□ **Yellow Jaundice**
□ **None**

*** Condition may require medication**

List any major illnesses not listed above: ……

……

Please check any medications and/or supplements taken in the past 12 months:

□ **Antibiotics or sulfa drugs**
□ **Tranquilizer**
□ **Aspirin (daily)**
□ **Insulin or diabetes medication**
□ **Herbal supplements**
□ **High blood pressure medication**
□ **Heart medications**
□ **Nitroglycerin**
□ **Anticoagulants (e.g. Coumadin, blood thinners)**
□ **Contraceptives**
□ **Bisphosphonates (used to treat osteoporosis, such as Fosamax, Boniva, Actonel and Zometa)**
□ **Phen-Fen or Redux**

List all medications/supplements you are currently taking: ……

……

I have answered all questions to the best of my knowledge. I will notify Dr. Joan Anderson of any change in my health or medication at each visit.

I authorize Dr. Joan Anderson to use the necessary local/topical anesthesia to perform my treatment in a safe, effective manner during this visit and any future visits. I understand that my failure to provide information on previous adverse reactions may cause unforeseen negative reactions. I release Dr. Joan Anderson of all liability regarding undisclosed medical history information.

…….. ……

Signature of Client or Guardian **Date**

……

If authorized guardian, relationship to client

…… ……

Witness Name **Date**

……

Witness Signature

…… ……

Doctor Signature **Date**

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MEDICAL HISTORY UPDATE

Please review your medical history on the previous pages and answer the following questions about any changes to your medical history since your last visit.

	Date / /	Client Initials	Dr. Initials	Date / /	Client Initials	Dr. Initials
Have there been any changes in your medical history since your last visit? If you answered yes, please explain and indicate in the medical history section on the previous page.	☐ **Y** ☐ **N**			☐ **Y** ☐ **N**		
Have you been hospitalized for any reason or had joint replacement surgery since your last visit?	☐ **Y** ☐ **N**			☐ **Y** ☐ **N**		
Have there been any recent changes or additions to your medications? If you answered yes, please explain and indicate in the medications/supplements section on the previous page.	☐ **Y** ☐ **N**			☐ **Y** ☐ **N**		
Are you presently using any herbs, teas, vitamins, or hormone replacements? If yes, please explain and indicate in the medications/supplements section on the previous page.	☐ **Y** ☐ **N**			☐ **Y** ☐ **N**		