Patient Information

Patient Name:_____ Preferred Name:_____

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

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Gender:_____ SSN:_____

E-Mail:_____ __Single __Married __Child

Employer:_____ Work Phone:_____

Emergency Contact:_____ Phone:_____

Referred By:_____

Parent/Guardian Information (if patient is under age 18)

Parent/Guardian Name:_____ Relationship to Patient:_____

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

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Gender:_____ SSN:_____

Employer:_____ Work Phone:_____

Insurance Information

Subscriber Name:_____ Relationship to Patient:_____

Date of Birth:_____ SSN:_____

Subscriber Employer:_____ Subscriber ID#:_____

Insurance Company:_____ Group #:_____

WESTCLIFFE FAMILY DENTAL

Name:_____ Date:_____

Dental Concerns

To help us provide you with exceptional quality care, we would like to get to know you a little better. When considering dental treatment which of the following (if any) are a concern to you? (Please explain)

__ Fear _____

__ Time _____

__ Budget _____

__ No sense of urgency _____

__ Trust in Dr or Staff _____

Dental Values

As providers all of the following are important to us, but which one is the most important to you? (Please explain)

__ Function _____

__Comfort _____

__Cosmetic _____

__ Longevity _____

Please list any additional information you would like our doctor, hygienist, and additional staff members to know.

Dental History

Reason for today's visit:_____
How often do you brush?_____ How often do you floss?_____
Approx date of last dental visit_____
Please mark all that apply

__ toothache
__ loose, chipped, cracked or broken fillings/teeth
__ food catches
__ flossing breaks or hurts
__ pain, clicking or popping of jaw
__ grinding of teeth
__clenching of jaw
__headaches
__ snoring/sleep apnea
__ sensitivity
__ hot
__ cold
__ sweet
__chewing
__touch
__ sinus problems
__gagging
__ dry mouth
__ dark or white spots on teeth
__ gums
__bleeding
__ tender or sore
__loose teeth
__teeth have shifted
__ bad breath
__sores or growths in mouth
__other _____

Medical History

Are you under physician care now? __Yes __No If yes_____

Have you ever been hospitalized or had a major operation? __Yes __No If yes_____

Have you ever had a serious head or neck injury? __Yes __No If yes_____

Are you taking any medications, pills, or drugs? __Yes __No If yes_____

Do you take, or have you taken

Phen-Fen or Redux? __Yes __No If yes_____
Have you ever taken Fosamax, Boniva,

Actonel or any other medications containing bisphosphonates? __Yes __No If yes_____

Are you on a special diet? __Yes __No If yes_____

Do you use tobacco? __Yes __No If yes_____

Do you use controlled substances? __Yes __No If yes_____

For Women are you
__ Pregnant __ Trying to get pregnant __nursing __ taking oral contraceptives

Are you allergic to any of the following?
__ Asprin __ Penicillin __ Codeine __ Acrylic __ Metal __ Latex __ Sulfa Drugs
__Local Anesthetics Other: _____

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

AIDS/HIV Positive	__Yes __No	Hemophilia	__Yes __No
Alzheimer's Disease	__Yes __No	Hepatitis A	__Yes __No
Anaphylaxis	__Yes __No	Hepatitis B or C	__Yes __No
Anemia	__Yes __No	Herpes	__Yes __No
Angina	__Yes __No	High Blood Pressure	__Yes __No
Arthritis/Gout	__Yes __No	High Cholesterol	__Yes __No
Artificial Heart Valve	__Yes __No	Hives or Rash	__Yes __No
Artificial Joint	__Yes __No	Hypoglycemia	__Yes __No
Asthma	__Yes __No	Irregular heartbeat	__Yes __No
Blood Disease	__Yes __No	Kidney Problems	__Yes __No
Blood Transfusion	__Yes __No	Leukemia	__Yes __No
Breathing Problems	__Yes __No	Liver Disease	__Yes __No
Bruise Easily	__Yes __No	Low Blood Pressure	__Yes __No
Cancer	__Yes __No	Lung Disease	__Yes __No
Chemotherapy	__Yes __No	Mitral Valve Prolapse	__Yes __No
Chest Pains	__Yes __No	Osteoporosis	__Yes __No
Cold Sores/Fever Blister	__Yes __No	Pain in Jaw Joints	__Yes __No
Congenital Heart Disorder	__Yes __No	Parathyroid Disease	__Yes __No
Convulsions	__Yes __No	Psychiatric Care	__Yes __No
Cortisone Medicine	__Yes __No	Radiation Treatment	__Yes __No
Diabetes	__Yes __No	Recent Weight Loss	__Yes __No
Drug Addiction	__Yes __No	Renal Dialysis	__Yes __No
Easily Winded	__Yes __No	Rheumatism	__Yes __No
Emphysema	__Yes __No	Scarlet Fever	__Yes __No
Epilepsy or Seizures	__Yes __No	Shingles	__Yes __No
Excessive Bleeding	__Yes __No	Sickle Cell Disease	__Yes __No
Excessive Thirst	__Yes __No	Sinus Trouble	__Yes __No
Fainting Spells/Dizziness	__Yes __No	Spina Bifida	__Yes __No
Frequent Cough	__Yes __No	Stomach/Intestinal Disease	__Yes __No
Frequent Diarrhea	__Yes __No	Stroke	__Yes __No
Frequent Headaches	__Yes __No	Swelling of Limbs	__Yes __No
Genital Herpes	__Yes __No	Thyroid Disease	__Yes __No
Glaucoma	__Yes __No	Tonsillitis	__Yes __No
Hay Fever	__Yes __No	Tuberculosis	__Yes __No
Heart Attack/Failure	__Yes __No	Tumors or Growths	__Yes __No
Heart Murmur	__Yes __No	Ulcers	__Yes __No
Heart Pacemaker	__Yes __No	Venereal Disease	__Yes __No
Heart Trouble/Disease	__Yes __No	Yellow Jaundice	__Yes __No

Have you ever had any serious illness not listed above? __Yes __No

If yes _____

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/Guardian Signature Printed Name Date