

# Patient Information

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Parent's Name if Minor \_\_\_\_\_

E-Mail \_\_\_\_\_

Home Address \_\_\_\_\_

Home phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell phone \_\_\_\_\_

Work phone \_\_\_\_\_

If You Have Insurance, Name of Insured \_\_\_\_\_

Insured Employed by \_\_\_\_\_

Name of Insurance Company (please bring card to first appt.) \_\_\_\_\_

How Did You Learn about Our Office \_\_\_\_\_

## Health History

Have you been hospitalized or under the care of a physician during the past 2 years? YES  No

If YES, please explain \_\_\_\_\_

### ALLERGIES

Are you allergic to (i.e. itching, swelling, rash, severe reaction) or made sick by any of the following

- |                                                 |                                                |                                          |                                              |
|-------------------------------------------------|------------------------------------------------|------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Latex                  | <input type="checkbox"/> Eggs                  | <input type="checkbox"/> Aspirin         | <input type="checkbox"/> Codeine             |
| <input type="checkbox"/> Penicillin/Amoxicillin | <input type="checkbox"/> Tylenol/Acetaminophen | <input type="checkbox"/> Darvocet/Darvon | <input type="checkbox"/> Vicodin/Hydrocodone |
| <input type="checkbox"/> Motrin/Ibuprofen       | <input type="checkbox"/> Demerol/Meperidine    | <input type="checkbox"/> Morphine        | <input type="checkbox"/> Fentanyl/Sublimaze  |
| <input type="checkbox"/> Sulfa                  | <input type="checkbox"/> Others _____          |                                          |                                              |

### FEMALE PATIENTS

Are you, or have you ever taken medication for osteoporosis?  YES  NO

Fosamax (alendronate) or Actonel (risedronate)

Are you, or is there a chance that you might be pregnant?  YES  NO

Are you breast-feeding?  YES  NO

Are you taking Birth Control Medication (pill, patch, shot)?  YES  NO

(Antibiotics may reduce the effectiveness of some contraceptives)

## REVIEW OF SYSTEMS (Check any conditions that you have or have had in the past)

FOR STAFF USE:

### HEAD & NECK

(taking medication for  YES  NO)

- |                                         |                                                                        |
|-----------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Cancer of the Mouth or Throat                 |
| <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> Radiation Therapy to the Jaws                 |
| <input type="checkbox"/> Other          | <input type="checkbox"/> Temporomandibular Joint Dysfunction (TMD/TMJ) |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### HEART

(taking medication for  YES  NO)

- |                                                  |                                                     |
|--------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Heart Surgery              |
| <input type="checkbox"/> Angina                  | <input type="checkbox"/> Pacemaker                  |
| <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Defibrillator              |
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Congestive Heart Failure   |
| <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Congenital Heart Condition |
| <input type="checkbox"/> Abnormal Rhythm         | <input type="checkbox"/> Infective Endocarditis     |
| <input type="checkbox"/> Heart Transplant        | <input type="checkbox"/> Shunts / Conduits          |

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### LUNGS

(taking medication for  YES  NO)

- |                                       |                                       |
|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Emphysema    |
| <input type="checkbox"/> Smoke/Smoked | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Other        |                                       |

\_\_\_\_\_  
\_\_\_\_\_  
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### ENDOCRINE/HORMONES (taking medication for YES NO)

- |                                          |                                           |
|------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Steroid Therapy | <input type="checkbox"/> Other            |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**STOMACH/KIDNEY/LIVER** (taking medication for  YES  NO)

- Ulcers  Liver Disease
- Kidney Disease  Hepatitis A,B or C
- Alcohol Drinks \_\_\_\_\_ day/wk

**BLEEDING/BLOOD** (taking medication for  YES  NO)

- Blood Thinners  Blood Clots in Legs or Lungs
- Anemia  Stroke
- Leukemia  Other

**NEUROLOGIC/PSYCHOLOGIC** (taking medication for  YES  NO)

- Seizure Disorder  Dementia
- Depression  Anxiety
- BiPolar Disorder  ADD/ADHD
- Other Neurologic / Psychiatric Disorder

**OTHER**

- Artificial Joint  Arthritis
- Substance Addiction  Fainting Spells
- Cancer  Chemotherapy
- Compromised Immune System
- Sleep Disorder/Snoring/Chronic Tiredness

ARE THERE ANY OTHER ASPECTS TO YOUR MEDICAL HISTORY THAT YOU FEEL WOULD BE IMPORTANT FOR US TO KNOW ABOUT? ARE YOU CURRENTLY TAKING ANY OTHER MEDICATIONS OR HERBAL SUPPLIMENTS?

**Dental History**

Approximate date of last exam/visit \_\_\_\_\_

Does dental treatment make you nervous?  NO  Slightly  Moderately  Extremely

Have you ever been treated for Periodontal Disease (gum disease, pyorrhea, trench mouth)?  YES  NO

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

<u>MOUTH</u>	YES
Bleeding, swollen or sore gums-----	<input type="checkbox"/>
Unpleasant taste / bad breath-----	<input type="checkbox"/>
Burning tongue / lips-----	<input type="checkbox"/>
Frequent blisters, lips / mouth-----	<input type="checkbox"/>
Swelling-----	<input type="checkbox"/>
Orthodontic treatment (braces) -----	<input type="checkbox"/>
Clicking / Popping jaw-----	<input type="checkbox"/>

<u>TEETH</u>	YES
Loose teeth-----	<input type="checkbox"/>
Sensitive to hot-----	<input type="checkbox"/>
Sensitive to cold-----	<input type="checkbox"/>
Sensitive to biting-----	<input type="checkbox"/>
Food impaction-----	<input type="checkbox"/>
Clenching / Grinding-----	<input type="checkbox"/>
Changes in bite-----	<input type="checkbox"/>

ALL ANSWERS TO THE PRECEEDING QUESTIONS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. IF THERE ARE ANY CHANGES TO MY HEALTH OR MEDICATIONS I WILL INFORM MEADE ZOLMAN FAMILY DENTISTRY P.C.

Signature of Patient, Parent or Guardian

Date

Reviewed with patient or their representative by Dr. \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_