Arnette Family Dentistry

Patient Information

First Name: _____ MI: _____ Last Name: _____ Todays Date: 05-08-2013

Sex: ☐ M ☐ F Birthdate: _____ Age: _____ SSN: _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Email: _____ What do you prefer for appointment reminders? ☐ Email ☐ Text ☐ Postcard

Address: _____ NC

Employer: _____ Bus Tel.: _____

Physician: _____ Physician Phone: _____

Emergency Contact : _____ Relationship: _____

Work : _____ Home: _____ Cell: _____

Have you ever been a patient of our practice? ☐ Yes ☐ No Has a family member ever been a patient of our practice? ☐ Yes ☐ No

How did you hear about our Practice? _____

Patient Health History

Reason for todays office visit? _____

		Yes	No
1.	Height: ' " Weight: 0 lbs Are you in good health?	☐	☐
2.	Have there been any general changes in your health in the past year?	☐	☐
3.	Are you under the care of a physician?	☐	☐
	If so, what are you being treated for? _____ Date of last visit? _____		
4.	Have you had an operation, illness, or hospitalized in the past 5 years?	☐	☐
	If so, describe: _____		
5.	Do you have any unhealed/recurrent injuries or inflamed areas, growths, or sore spots in or around your mouth?	☐	☐
6.	Do you have a prosthetic joint or implant?	☐	☐
	If so, describe: _____		
7.	Have you had a heart valve replacement or vascular graft?	☐	☐
8.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐

Do you have a history of:

Yes	No		Yes	No		Yes	No	
☐	☐	A Tumor Or Growth	☐	☐	Difficulty Breathing	☐	☐	Low Blood Pressure
☐	☐	Alcohol Abuse	☐	☐	Drug Abuse	☐	☐	Low Blood Sugar
☐	☐	Are You on Dialysis?	☐	☐	Emphysema	☐	☐	Mental Health Problems
☐	☐	Arthritis / Joint Disease	☐	☐	Epilepsy	☐	☐	Mitral Valve Prolapse
☐	☐	Asthma	☐	☐	Eye Disease / Glaucoma	☐	☐	Osteonecrosis
☐	☐	Bleeding Tendency or Excessively	☐	☐	Fainting Spells	☐	☐	Osteoporosis / Osteopenia
☐	☐	Blood Disorder Such as Anemia	☐	☐	Gall Bladder Trouble	☐	☐	Other Lung Trouble
☐	☐	Blood Transfusion	☐	☐	Hay Fever / Sinus Problems	☐	☐	Pneumonia, Bronchitis, Chronic Cough
☐	☐	Bruise Easily	☐	☐	Hearing Impaired	☐	☐	Problems with Immune System
☐	☐	Cancer	☐	☐	Heart	☐	☐	Radiation Therapy / Chemothera
☐	☐	Cardiac Pacemaker	☐	☐	Heart Attack(s)	☐	☐	Rheumatic Fever
☐	☐	Chest Pain/Angina	☐	☐	Heart Surgery	☐	☐	Sexually Transmitted Diseases
☐	☐	Chronic Fatigue / Night Sweats	☐	☐	Hepatitis, Jaundice, or Liver Disease	☐	☐	Snoring / Sleep Apnea
☐	☐	Chronis Obstructive Pulmonary Disease	☐	☐	High Blood Pressure	☐	☐	Stomach Ulcers
☐	☐	Contagious Diseases	☐	☐	Hip or Joint Replacement	☐	☐	Stroke
☐	☐	Convulsions / Epilepsy	☐	☐	HIV / AIDS	☐	☐	Swollen Ankles
☐	☐	Damaged Heart Valves	☐	☐	Immunosuppressed	☐	☐	Thyroid Trouble
☐	☐	Delay in Healing	☐	☐	Infectious Mononucleosis	☐	☐	Tuberculosis
☐	☐	Diabetes	☐	☐	Irregular Heart Beat			
☐	☐	Dieting	☐	☐	Kidney Trouble			

Arnette Family Dentistry

For Women Only:

	Yes	No		Yes	No
Are you taking birth control pills?	☐	☐	Are you nursing?	☐	☐
Are you pregnant?	☐	☐	Is there a possibility of pregnancy?	☐	☐

Expected delivery date: _____

NOTE: *Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult with your physician/gynecologist for assistance regarding additional methods of birth control.*

Medications and Allergies:

Have you taken, or are now taking:	Yes	No	**Are you allergic to, or had a reactin to:**	Yes	No
Blood thinners (Coumadin, Plavix,Aspirin, Pradaxia, Aggrenox, Vitamin E, Ginko biloba, Fish oil)	☐	☐	Local anesthetic (numbing meds.)	☐	☐
Any bone density medications / bisphosphonates (Aredia, Zometa, Fosamax, Actonel, Reclast, Boniva)	☐	☐	Penicillin	☐	☐
Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis	☐	☐	Codeine or other narcotics	☐	☐
Have you ever taken diet pills	☐	☐	Latex	☐	☐
Any natural product, herbal supplement, or homeopathic remedy	☐	☐	I have no known allergies	☐	☐

Please list any medications you are taking, including non-prescription drugs:

Please list any allergies not indicated above:

List any conditions/problems concerning your health that the Doctor should know about:

Dental History

Date of last dental visit? _____

Date of last cleaning? _____

Name of previous dentist: _____

Have you or a family member ever been treated for periodontal disease (gum disease) ☐ Yes ☐ No

Have you ever had complications after an extraction?	☐ Yes	☐ No
Have you ever had orthodontic treatment?	☐ Yes	☐ No
Have you grind or clench your teeth?	☐ Yes	☐ No

If you could change something about your smile, what woudl it be:

If you could change something about your smile, what would it be?

☐ Close Spaces	☐ Replace old crowns or
☐ Improve health of gums	☐ Replace old fillings
☐ Repair chipped teeth	☐ Straighter
☐ Replace missing teeth	☐ Whiter

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the injuries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Patient: _____ Reviewed By: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____

Authorization

I authorize my general dentist and his / her designated staff, to perform a dental examination, for the purpose of diagnosis and treament planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. I consent to the treatment indicated to me on my treatment form as a result of the examination, including the use of anesthetics, as may be deemed neessary by the doctor. In addition, if medically necessary, I authorize the release of any informatin acquired in the course of my examination and treatment.

Patient: _____ Parent/Guardian (if patient is a minor): _____ Date: _____

Witness: _____ Doctor: _____ Date: _____