ALLEN PARK DENTAL CARE

PATIENT INFORMATION

Name ______________________

I prefer to be called ______________________

Address ______________________

Cell Phone ______________________

City ______________ Zip ________

Home Phone ______________________

Email ______________________

Work Phone ______________________

Employer ______________________

SS # ______________________

Date of Birth ______________________

Marital Status (please circle) S M D W

How did you hear about our office? ______________________

How may we contact you for appointment reminders? (please circle all that apply)

email work phone home phone cell phone cell phone text message

INSURANCE INFORMATION

Policy Holder's Name ______________________

Date of Birth ______________________

Employer ______________________

SS # ______________________

Insurance ______________________

Secondary Insurance ______________________

DENTAL HISTORY

Are you have any of the following problems?

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, jaw joint, neck pain
- ☐ Dry mouth, difficulty swallowing
- ☐ Teeth or filling breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth
- ☐ Sleep apnea, snoring

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

- ☐ Dentures/Partial dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

Do you smoke or chew tobacco? How much?

____

Why did you leave your previous dentist?

____

If you could change your smile, you would:

- ☐ Make them whiter and brighter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings w/tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

Please rate on a scale of 1-10 (10 is highest):

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where is your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?

____

What is the most important thing to you about your dental visit today?

____

MEDICAL HISTORY

Please circle "Yes" or "No" to all questions below.

Yes No Are you in good health?

Yes No Have you been told to take premedication/antibiotics before a dental treatment?

If yes, for what reason? ______

Yes No Any change in your health within the last year? ______

Yes No Hospitalized or a serious illness within the last 5 years? ______

Yes No Being treated by a physician now? For what? ______

Yes No Do you have any allergies? ______

Do you have or have you ever had?

Yes No Shortness of breath
Yes No Sinus Problems
Yes No Asthma
Yes No Emphysema
Yes No Tuberculosis
Yes No Sleep apnea/snoring

Yes No High Blood Pressure
Yes No Heart Disease
Yes No Heart Murmur
Yes No Mitral Valve Prolapse
Yes No Stroke
Yes No Hearth Attack
Yes No Heart Defect
Yes No Pacemaker
Yes No Prosthetic Heart Valve
Yes No Chest Pain
Yes No Anemia
Yes No Bleeding problem
Yes No HIV positive/AIDS/ARC
Yes No Hepatitis A B or C
Yes No Stomach problem/ulcer
Yes No Diabetes
Yes No Kidney/bladder-disease
Yes No Thyroid/adrenal disease
Yes No Liver Disease
Yes No Herpes/Cold sore/ fever blister
Yes No Human papillomavirus

Yes No Seizures
Yes No Dizziness, fainting
Yes No Depression
Yes No Anxiety

Yes No Surgeries
Yes No Artificial Joint

Yes No Cancer
Yes No Radiation
Yes No Chemotherapy

Do you take or have you ever taken:

Yes No Recreational drugs
Yes No Alchohol
Yes No Tobacco in any form
Yes No Fosomax/ Osteoporosis meds
Yes No Contraception/birth control
Yes No Vitamins
Yes No Medications - list below

______ to treat ______
______ to treat ______
______ to treat ______
______ to treat ______
______ to treat ______
______ to treat ______

Do you have or have you had any other medical problems not listed above? ______

______

______

Patient Signature (guardian if a minor) Date