# 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

**Do** you have any of the following problems?

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, jaw joint, neck pain
- ☐ Broken fillings or teeth
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth
- ☐ History of gum treatment
- ☐ History of braces
- ☐ Denture/ partial denture

Dietary Cavity Risk: (Do you have any of the following)

- ☐ Dry mouth
- ☐ Acid reflux/ heartburn
- ☐ Sugar & acid in your diet

What do you snack on? _____

What do you drink? _____

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
- ☐ 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?

_____

OVER →

## MEDICAL HISTORY

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

Yes No Have you been told to take premedication/antibiotics before a dental treatment?
If yes, for what reason _____ Which antibiotic? _____

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? (Please circle "Yes" to all questions and give details for yes answers.)

Yes No Sinus Problems
Yes No Asthma
Yes No Emphysema
Yes No COPD
Yes No Snoring
Yes No Sleep Apnea (treated with CPAP, Oral Appliance, surgery) _____
Yes No Tuberculosis
Yes No High Blood Pressure
Yes No Heart Disease
Yes No Heart Defect
Yes No Heart Murmur/Mitral Valve Prolapse
Yes No Heart Attack _____
Yes No Pacemaker
Yes No Prosthetic Heart Valve
Yes No Stroke
Yes No Chest Pain
Yes No Acid Reflux/Heart burn
Yes No Ulcers
Yes No Digestive Trouble _____
Yes No Diabetes – Type 1 or Type 2
Yes No Cancer – type (treated with radiation, chemo, surgery) _____
Yes No Kidney/ Bladder Disease
Yes No Liver Disease
Yes No Surgeries _____
Yes No Artificial Joint _____

Yes No Seizures
Yes No Dizziness/fainting
Yes No Depression
Yes No Anxiety
Yes No Cold Sores/ Fever Blisters
Yes No HPV
Yes No Bleeding Problems
Yes No Anemia
Yes No Hepatitis A B or C

Do you take or have you ever taken:

Yes No Vitamins
Yes No Alcohol
Yes No Tobacco (Circle: Smoke, Chew, Vape)
Yes No Recreational Drugs
Yes No Birth Control/ Contraception
Yes No Bone Density Medications
Yes No Blood Thinners
Yes No Medications (Please List Below)

_____ to treat _____
_____ to treat _____
_____ to treat _____
_____ to treat _____
_____ to treat _____

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

**X** _____

Patient Signature (guardian if a minor) Date