DENTAL L  VE

150 Francam Drive Suite 100

Fayetteville, NC 28311

(910)500-6660

Patient Info: Last Name_____ First Name_____ MI___

Address_____

City_____ ST____ Zip Code_____

Driver's License Number_____

Phone Number (Home)_____ (Cell)_____

Date of Birth____/____/_____ Social Security____-____-_____

Emergency Contact Information: Name_____

Phone Number (Home)_____ (Cell)_____

Relationship to Patient_____

Physician Info: Physician name_____ Phone Number_____

Address_____

City_____ ST____ Zip Code_____

Medical History: Date of last physical exam____/____/_____

List any medications you are currently taking (pills, patches, inhalers, etc.) including non-prescription drugs and vitamins.

_____

_____

_____

Have you had any serious illnesses, operations, or been hospitalized in the past 5 years? If so, please list when, where, and why.

Do you smoke or use tobacco products? If yes, what and how much?

Do you suffer from Depression? _____Yes _____No

Please check below any of the conditions or allergies that apply to you:

☐ Allergy to Aspirin	☐ Pre-Med-Clind.	☐ Diabetes	☐ Kidney Disease
☐ Allergy to Latex	☐ Pre-Med-Amoxicillin	☐ Arthritis	☐ Sinus Problems
☐ Anemia	☐ Allergy to Codeine	☐ Allergy to Penicillin	☐ Respiratory Problems
☐ Asthma	☐ Other Allergies: _____	☐ Fainting	☐ Tuberculosis
☐ Cancer	☐ Anxiety	☐ Heart Attack	☐ Allergy to Hay Fever
☐ Epilepsy	☐ Head Injury	☐ Stroke	☐ Allergy to Sulfa
☐ Glaucoma	☐ HIV	☐ Shortness of Breath	☐ Coronary Disease
☐ Heart Murmur	☐ Heart valve damage	☐ Mitral Valve Prolapse	☐ Radiation Treatment
☐ High Blood Pressure	☐ Mental Disorder	☐ Jaundice	☐ Any other Pre - Medications
☐ Liver Disease	☐ Excessive Bleeding	☐ Heart Angina	☐ Bisphosphonate-Oral
☐ Pacemaker	☐ Pregnant	☐ Artificial Joints	☐ Bisphosphonate- IV
☐ STD	☐ Ulcers	☐ Hepatitis	☐ Thoughts of Suicide
☐ Tumors	☐ Stomach Problems	☐ Heart Disease	
☐ Rheumatic fever	☐ Rheumatism	☐ Frequent Headaches	
☐ Dizziness	☐ Blood Disease		

Do you have any other diseases, conditions, or problems not listed that you think we should know about? ___Yes ___No

If yes, please list them.

_____

Dental History: Date of last dental visit___/___/_____

How often do you get teeth cleanings? _____

Have you ever had an acute sore mouth or gum boils(abscess)? ____Yes ____No

Have you ever had any periodontal or gum treatments? ____Yes ____No

Have you ever had braces or any other orthodontic treatment to help you straighten your teeth? ____Yes ___No

Please check all that apply to you:

☐ Bleeding Gums	☐ Bad Breath	☐ Bad taste in mouth	☐ Jaw clicking or popping	☐ Sensitivity to Sweets
☐ Trouble chewing	☐ Ear Pain	☐ Sensitivity to Hot	☐ Sensitivity to Cold	☐ Jaw Pain

Have you ever had any serious problems associated with previous dental treatment? If yes, please explain.

_____

Patient Concerns:

Do you feel your teeth are white enough? ____Yes ____No

Is there anything about your smile that you would like to change? ____Yes ____No

Do you feel that you have enough teeth to chew with? ____Yes ____No

Are the cosmetics of your smile important to you? ____Yes ____No

What is your main dental complaint or concern?

<u>What do you consider most important or your main priority?</u>

☐ Elimination of Pain	☐ Appearance	☐ Function of Teeth
☐ Eradication of Infection	☐ Preservation of Natural Teeth	☐ Avoidance of removable dentures

☐ I testify that the above information given is an accurate representation of my medical information.

Signature:_____ Date:_____