ROCHESTER FAMILY DENTISTRY

Welcome!

Patient Information

Patient Name _____ Date of Birth _____
Social Security # _____ Marital Status _____
Patient Address _____ City, State, Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ Email _____
What is the best way to confirm your dental appointment? _____
Patient's Employer _____ Present Position _____
Spouse's Employer _____ Present Position _____
Will the fees for our services be offset by dental insurance? Yes / No
Subscriber Name/DOB _____ Relationship to Patient _____
Dental Insurance Company _____
Identification#/SSN _____ Group # _____
Who may we thank for referring you to our office? _____

Dental History

What prompted you to seek dental care at this time? _____
How long has it been since your last dental visit? _____
When was your last complete x-ray exam? _____
When did you last have your teeth cleaned? _____
How do you feel about the appearance of your teeth? _____
Are you planning to keep your remaining teeth your whole lifetime? _____
Has fear of discomfort kept you from regular dental care? _____

Have you ever had any of the following dental procedures done? If so, please explain.
Gum Treatments or Periodontal Surgery? Yes/No _____
Orthodontic Treatment? Yes/No _____
Oral Surgery? Yes/No _____
Endodontic Treatment? Yes/No _____
Have you ever whitened your teeth? Yes/No _____ Are you interested in whitening? Yes/No _____

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

___ Bleeding/sore gums
___ Sensitivity to hot/cold
___ Frequent sores or blisters
___ Clicking/popping jaws
___ Loose teeth
___ Frequent cavities
___ Unpleasant breath
___ Sensitivity to biting pressure
___ Burning tongue or lips
___ Pain or soreness of jaw joint
___ Shifting of teeth/change in bite
___ Build up a lot of plaque/calculus
___ Dry mouth
___ Sensitivity to sweets
___ Swelling/lumps in the mouth
___ Clenching/grinding your teeth
___ Difficulty opening/closing jaw
___ Areas where food gets caught

How often do you brush? _____ How often do you floss? _____
What other products/rinses do you use? _____
If you could change anything about your teeth or smile, what would it be? _____
Is there anything we can do to make your dental appointment more comfortable? _____
Do you have any other dental concerns you'd like to discuss? _____
_____

I certify that the above information is complete and accurate.
Patient/Guardian Signature _____ Date _____
Dentist's Initials _____

Please Complete Reverse Side.

Medical History

Please take the time to complete this form with your current medical information. Your medical history can influence your susceptibility to certain dental conditions. Please inform us of any medical changes in the future.

Physician's Name _____ Physician's Address _____
Are you currently under the care of a physician? Yes / No Why? _____

Please check and/or circle any of the following conditions that you have or have had in the past:

___ Abnormal Bleeding
___ Anemia/Blood Disorders
___ Angina (Chest Pain)
___ Any Heart Problems
___ Arthritis/Rheumatism
___ Artificial Heart Valve/Pacemaker
___ Asthma/Hay Fever
___ Blood Pressure: High or Low
___ Cancer, Type:_____
___ Diabetes: Type 1 or Type 2
-Controlled or Uncontrolled?
-By Medication or Diet?
___ Epilepsy or Seizures
___ Fainting or Dizzy Spells
___ Frequent Headaches, Neck or Shoulder Aches
___ Glaucoma or Light Sensitivity
___ Heart Murmur
___ Hepatitis, Type: _____
___ Herpes/Cold Sores/Shingles
___ Joint Replacement _____
When? _____
___ Kidney/Liver Problems
___ Mental/Emotional Disorders
___ Nervous Problems
___ Organ Transplant, Type: _____
___ Osteoporosis/Osteopenia
___ Radiation/Chemotherapy
___ Rheumatic Fever
___ Sinus Problems
___ Stroke
___ Tested Positive for HIV
___ Thyroid: Hypothyroid/Hyperthyroid
___ Tuberculosis
___ Venereal Disease

Have you had a serious disease not listed above? Yes / No _____

Have you ever taken Bisphosphonate medications (Fosamax, Boniva, Prolia, Zometa)? Yes / No
*If yes, which medication?*_____ *When?*_____ *For how long?*_____

Do you smoke, chew, use snuff, or any other forms of tobacco? Yes / No *Circle those that apply.*
How long? _____ *How much?* _____ *Are you interested in quitting?* _____

Do you consume alcohol or use recreational drugs? Yes / No *Circle those that apply.*
How much? _____

Please list any medications you are currently taking (prescription, non-prescription, supplements etc.):
_____
_____

Are you allergic to or have you had any reaction to:

___ Local Anesthetics (Lidocaine, etc)
___ Latex
___ Penicillin / Amoxicillin
___ Erythromycin
___ Sulfa Drugs
___ Aspirin
___ Codeine
___ Ibuprofen
___ Nickel / Other Metals
___ Other: _____

Women only: Do you use birth control medications? Yes / No
Are you pregnant? Yes / No
Are you nursing? Yes / No

I certify that the above information is complete and accurate.
Patient/Guardian Signature _____ Date _____
Dentist's Initials _____