Dental and Health Information

Patient Name_____Preferred Name_____ D.O.B._____

- Rate your teeth and mouth from 1 (unsatisfied) to 5 (satisfied)

  ____Appearance

  ____Function (eating and speaking)

  ____General comfort and sensitivity

- What is the reason for your visit today? (check all that apply)

  ☐ Checkup ☐ Missing teeth ☐ Sore tooth ☐ Sore gums ☐ Whitening

  ☐ Jaw/TMJ pain ☐ Change appearance of teeth (veneers, remove old silver fillings, etc.)

  ☐ Other:_____

- Describe your home brushing/flossing routine_____
- What type of toothbrush/toothpaste do you use?_____
- Have you whitened your teeth? ☐ Yes ☐ No
- Former Dentist_____ Location_____
- Approx date of last dental appt_____ Unfinished treatment?_____

  What frequency did your former dentist recommend for cleanings? _____
- Have you ever had scaling and root planing (deep cleaning)? ☐ Yes ☐ No
- Is there anything you'd like us to know so that we may best meet your dental needs (ex: anxiety concerns, previous negative experiences, etc.)? _____

Medical History

- Do you have any drug or medical allergies? ☐ Yes ☐ No Please list. _____

  Other allergies? ☐ Yes ☐ No Please list. _____
- Have you ever been told that you need to take an antibiotic before a dental visit? _____
- List past and current health problems or conditions (ex: diabetes, high blood pressure, infections, cancer, hepatitis, etc.)._____
- List past major medical procedures (ex: joint replacement, artificial valves, stents, etc).

  _____
- List any congenital heart condition, history of infective endocarditis or ANY other heart problem.

  _____
- When was your last exam by your medical doctor? _____
- What prescription and over-the-counter medications are you currently taking?

  _____
- Where do you get your drinking water? Check all that apply. ☐ "City" water ☐ Well water ☐ Bottled
- Have you EVER taken Fosamax or other bisphophonates? ☐ Yes ☐ No
- Have you used an inhaler? ☐ Yes ☐ No
- Do you use tobacco products? ☐ Yes ☐ No If yes, what form? _____
- Women: are you pregnant? If yes, congratulations! How many weeks? _____

Patient/Guardian signature_____Date_____

WELCOME

We are pleased to welcome you to Droel Family Dentistry. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

Patient Information

Name (Last, First and Middle Initial)_____Preferred Name_____

Address_____ City_____ State____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

D.O.B.____/____/_____ Sex_____ Marital Status_____Spouse's Name_____

Email address_____

Employer/School_____

Employer/School Address_____

Emergency Contact_____Relationship_____Phone_____

How did you hear about our practice?_____

Dental Insurance

Policyholder's Name (Last, First, and M.I.)_____
D.O.B.____/____/_____SSN_____-_____-_____ Relation to Patient_____

Address (if different from patient)_____

Employer_____Employer Address_____

Insurance Company_____Group #_____ Subscriber ID#_____

Address_____ City_____ State____ Zip_____

Insurance Company Phone #_____

Additional Dental Insurance

Policyholder's Name (Last, First, and M.I.)_____
D.O.B.____/____/_____SSN_____-_____-_____ Relation to Patient_____

Address (if different from patient)_____

Employer_____Employer Address_____

Insurance Company_____Group #_____ Subscriber ID#_____

Address_____ City_____ State____ Zip_____

Insurance Company Phone #_____