HAMILTON FAMILY DENTISTRY PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please don't hesitate to ask.

Patient Name ______________________ Date of Birth __________ Sex ______ Age ______

Home Address ______________________ City __________ State ______ Zip ______

Billing Address (if different) ______________________ City __________ State ______ Zip ______

Home Phone ______________________ Cell __________ Email __________

SS# ______________________ Work Phone ______________________

Emergency Contact & Phone # ____

Employer/Occupation ____

Primary Dental Insurance ______________________ ID # __________ Group # __________

Secondary Dental Insurance ______________________ IID # __________ Group # __________

Subscriber's Name ______________________ Date of Birth __________ SS# __________

Name Of Your Medical Doctor ______________________ Date Of Last Visit To Medical Doctor __________

Responsible Party ______________________ Relationship To Patient __________

DENTAL HEALTH HISTORY

Name Of Your Former Dentist: ______________________ How Long Since Your Last Cleaning __________

Have you experienced any of the following problems:

Bleeding gums [Y] [N]

Bad breath or sour taste in mouth [Y] [N]

Burning sensations in mouth [Y] [N]

Soreness in jaw [Y] [N]

Is it hard for you to open wide? [Y] [N]

Clicking or popping in jaw [Y] [N]

Do you wear dentures/partials [Y] [N]

Ever been injured in your mouth or head [Y] [N]

Prolong bleeding [Y] [N]

Do you wear a nightguard [Y] [N]

Sensitivity to hot & cold [Y] [N]

Any pain in any of your teeth [Y] [N]

Clenching or grinding of teeth [Y] [N]

Date of last X-rays ______________________

Does having dental treatment make you afraid or nervous? [Y] [N]

If yes, what specific things bother you? __________

____

____

If you could change anything about your smile which of the following would you want?

Whiter	[Y] [N]	Close space or spaces	[Y] [N]	Replace chipped teeth	[Y] [N]
Replacing missing teeth	[Y] [N]	Replace old crowns	[Y] [N]	Remove silver fillings	[Y] [N]
Remove stains/spots on teeth	[Y] [N]	Excess showing of teeth	[Y] [N]	Replace old plastic filling(s)	[Y] [N]
Straighter	[Y] [N]	Less gum showing	[Y] [N]	Reshape/resize my teeth	[Y] [N]

MEDICAL HEALTH HISTORY

What Medications Are You Currently Taking: ______

Any Hospitalizations In The Last 5 years? ______

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

	Yes	No
Heart Problems	☐	☐
Heart Attack	☐	☐
Heart Surgery	☐	☐
Blood Pressure Problem	☐	☐
Rheumatic Fever	☐	☐
Pacemaker	☐	☐
Artificial Heart Valve	☐	☐
Blood Problems	☐	☐
Easy Bruising	☐	☐
Abnormal Bleeding	☐	☐
Easy Bruising	☐	☐
Blood Disease (Anemia)	☐	☐
Ever Require A Blood Transfusion?	☐	☐
Allergy Problems	☐	☐
Sinus Problems	☐	☐
Asthma	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Joint Replacement	☐	☐
Fainting Spells, Seizures or Epilepsy	☐	☐
Stroke(s)	☐	☐
Thyroid Problems	☐	☐
Persistent Cough or Swollen Glands	☐	☐
Premedications Required by Physician	☐	☐
Cancer/Tumor	☐	☐

Type ______

	Yes	No
Radiation	☐	☐
Chemotherapy	☐	☐

Are You Allergic, Or Have You Reacted Aversely To Any Of The Following:

	Yes	No
Local Anesthetics (Novocaine)	☐	☐
Penicillin Other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates, Sedatives Or Sleeping Pills	☐	☐
Aspirin, Acetaminophen Or Ibuprofen	☐	☐
Codeine, Demerol Or Other Narcotics	☐	☐
Reaction To Metals	☐	☐
Latex Or Rubber Dam	☐	☐
Shellfish	☐	☐
Red Wine	☐	☐
Other	☐	☐

	Yes	No
Diabetes	☐	☐
Tuberculosis Or Other Respiratory Disease	☐	☐
Do You Smoke?	☐	☐
If So, How Much	☐	☐
Hepatitis, Jaundice Or Liver Trouble	☐	☐
Herpes, HPV Or Other STD	☐	☐
HIV-Positive/AIDS	☐	☐
Glaucoma	☐	☐
Epilepsy Or Other Neurological Disease	☐	☐
History Of Drug Or Alcohol Use	☐	☐
History of Cocaine Use	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about? If so, please describe: ______

______

During The Past 12 Months, Have You Taken Any Of The Following:

	Yes	No
Coritisone (Steroids)	☐	☐
Cocaine	☐	☐
Male Enhancements	☐	☐

Women

	Yes	No
Are You Taking Contraceptives Or Other Hormones?	☐	☐
Are You Pregnant?	☐	☐
If So, Expected Due Date	☐	☐
Are You Nursing?	☐	☐

Notes ______

______

______

______

______

Patient Signature ______

Dentist Initials ______