PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents names _____ Home phone _____ Work phone _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

Whom may we thank for referring you to our office? _____ ❑ Phonebook

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

Please add anything else you would like us to know about:_____

Signature of patient (or parent) _____ Date _____

Michael A. Walsh D.D.S, S.C.

General Dentistry
Cosmetic & Implant Dentistry

Dental Health History Form

Today's Date_____

Patient Name: First_____MI_____ Last_____Nickname_____

What is important to you in a dentist or dental practice?_____

Date of last x-rays and exam?_____**Date of last cleaning**_____

Have you had problems with prior dental treatment?_____

Are you experiencing any discomfort now?_____

Have you ever been pre-medicated prior to dental treatment? Yes □ No□

If yes, why?_____

Have you been anxious about having dental treatment? Yes□ No□

What concerns do you currently have with your oral health or smile? *(check all that apply)*

□ jaw joint pain
□ clenching or grinding of teeth
□ discolored teeth
□ crowding/crooked teeth
□ missing teeth
□ spaces in between teeth
□ loose tooth/teeth
□ tooth shape or size
□ unhappy with appearance of teeth
□ overbite
□ underbite
□ uncomfortable bite
□ old fillings
□ old crowns
□ speech problems
□ too much gum tissue when I smile
□tooth sensitivity to hot/cold or biting
□ food gets caught in between teeth
□ difficulty chewing
□ bad breath
□other_____
_____

Have you ever had orthodontic treatment? □ Yes □ No **If yes, when?**_____

Have you ever had periodontal treatment (deep cleanings, root planning, or periodontal surgery)? □ Yes □ No

If yes, when?_____

Have you ever whitened your teeth in the past? □ Yes □ No

Are you interested in learning more about the following? *(check all that apply)*

□ teeth whitening
□ clear aligners (Invisalign)
□ veneers/porcelain crowns
□ tooth colored fillings
□ dental implants
□ how to prevent periodontal disease
□ at home oral hygiene care
□ replacing mercury fillings
□ tooth replacement options

Would you like to listen to music during your visit? □ Yes □ No **If so, whats your favorite artist/song?**_____

What is a cool/interesting fact about you?_____

What can we do to make this your best dental experience yet?_____

E-MAIL ADRESS-_____ CELL PHONE #