ADULT'S PATIENT FORM

Name:________________________________Title:________________

Mailing Address:____

City:____________________Prov:________Postal Code:__________

Home Phone:__________________Cell Phone:____________________

Emergency Phone:____

E-mail Address:____

Telephone preference: ❑ Home ❑ Business ❑ Cell

Date of Birth:(MM/DD/YY)__________Occupation:________________

How did you hear about Southdown Dental?

❑ Family/Friend ❑ Sign ❑ Physician______________________

❑ Other (Please Specify) ______________________________________

Responsible Person for Account

Name:_____________________Relationship:____________________

Address:____

City:______________________________Postal Code:______________

Telephone Home:_________________ Business:_________________

Physician Name:______________________ Telephone:______________

Address:____

City:_______________________________ Postal Code:_____________

MEDICAL ALERT

Primary Insurance

Subscriber:__________________________

DOB: (MM/DD/YY)_____________________

Employer:___________________________

Ins Company:_________________________

Policy Group Plan #:___________________

Contract ID/Subscriber ID #:_____________

Secondary Insurance

Subscriber:__________________________

DOB: (MM/DD/YY)_____________________

Employer:___________________________

Ins Company:_________________________

Policy Group Plan #:___________________

Contract ID/Subscriber ID #:_____________

DENTAL HISTORY

Tell me about the dentistry you have had completed previously:

____

How frequently did you see your dentist?____

Have you had local anaesthetic at the dentist? ❑ Yes ❑ No Any Adverse reactions? ____________________________

What do you do at home to care for your teeth? ____

Is there any area that catches food? _______________________ Catches Floss? ___________________________

Do your gums ever feel tender or bleed? ____

Have you lost any teeth? __________________________ Why?___________________________________

Do you notice yourself clenching or grinding your teeth?____

Do you ever suffer from headaches?____

Does your jaw crack or pop when you open or close your mouth?____

Tell me what you liked about your last dental office:____

Is there anything you didn't like about your last dental office?____

If you could change anything about your smile or your teeth what would you change?_________________________

MEDICAL HISTORY

Patient Name ____

Question	Answer	Details
Are you being treated for any medical problem presently?	❑Yes ❑No	If yes: condition________________________________
Are you allergic to any medications?	❑Yes ❑No	____
Do you bruise easily ❑ or have prolonged bleeding ❑ ?	❑Yes ❑No	____
Do your ankles or feet swell?	❑Yes ❑No	____
Do you experience shortness of breath or chest pain?	❑Yes ❑No	____
Do you have frequent headaches?	❑Yes ❑No	____
Do you have pain in your ear(s)?	❑Yes ❑No	____
Do you have difficulty swallowing?	❑Yes ❑No	____
Have you ever had an injury to your head, face or jaw?	❑Yes ❑No	____
Have you ever had any major surgery?	❑Yes ❑No	What & When________________________________
Do you smoke cigarettes ❑ cigars ❑ chewing tobacco ❑ ?	❑Yes ❑No	How many per day?____________Years?__________
If yes are you thinking about quitting smoking?	❑Yes ❑No	When?_______________How?_________________
Do you smoke any recreational drugs?	❑Yes ❑No	____
Do you drink alcohol?	❑Yes ❑No	Drinks per week?_____________________________
Women: Are you or is there a chance you may be pregnant?	❑Yes ❑No	If yes: What trimester?________________________

Have you ever been treated or are you presently being treated for any of the following: (check only the ones that apply)

❑ Rheumatic Fever	❑ High Blood Pressure	❑ Pacemaker	❑ Organ Transplant
❑ Lung Disease	❑ Gall Bladder Disease	❑ Jaundice	❑ Psychiatric condition
❑ Heart Murmur	❑ Joint Replacement	❑ Leukemia	❑ Mental condition
❑ Heart Disease	❑ Liver and Kidney Disease	❑ GERD	❑ Venereal disease
❑ Tuberculosis	❑ Stroke	❑ COPD	❑ Herpes(cold sores)
❑ Cancer	❑ Epilepsy	❑ Thyroid	❑ Eating disorder
❑ Heart Attack	❑ Diabetes	❑ Anemia	❑ Hay Fever
❑ Scarlet Fever	❑ Diphtheria	❑ Arthritis	❑ Asthma

Are you presently under the care of a medical specialist? ❑ Yes ❑ No Which specialist?_________________________________

Are you taking medications? ❑ Yes ❑ No

Please list names and dosages and for what condition

Name of medication	Dosage	Condition

NOTES:____

____

Have you ever tested positive for Hepatitis? ❑ Yes ❑ No H.I. V. (AIDS)? ❑ Yes ❑ No

Are there any other medical concerns that we should be aware of?____

The above information is completed to the best of my knowledge and I have not omitted any pertinent information.

_____________________________ _________________ ________________________________

Client/ Guardian Signature MM/DD/YY Dentist Signature