SHORT PUMP FAMILY DENTISTRY

NEW PATIENT INFORMATION

Date: _____

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, don't hesitate to ask.

Patient name: First _____ Last _____ Date of birth: _____/_____/_____ Sex: M / F

Address: _____ City: _____ State: _____ Zip:_____

Home phone: (____)_____ Cell: (___)_____ Email:_____

May we contact you via (Please check) : ____ (Home phone) _____ (Cell phone) _____ (Email) _____ (All above listed)

SS #: _____ Employer/ Occupation: _____ Work phone: _____

Spouse/Significant other's name: _____ Contact #:_____

Emergency Contact: _____ Relationship: _____Phone #: _____

Primary dental insurance: _____ Group #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: ____/_____/_____ SS#: _____

Primary care physician: _____ Phone: _____

Date of last visit to dentist: _____ Who may we thank for the referral? _____

DENTAL HEALTH Yes / No

Are you apprehensive about dental treatment? _____ □ □
Any problems with previous dental treatments? _____ □ □
Do you gag easily? _____ □ □
Do you wear dentures? _____ □ □
Does food catch between your teeth? _____ □ □
Do you have difficulty chewing your food? _____ □ □
Do you avoid brushing part of your mouth due to pain?__ □ □
Do your gums bleed easily? _____ □ □
Do your gums bleed when you floss? _____ □ □
Do your gums feel swollen or tender? _____ □ □
Have you ever noticed slow-healing sores in your mouth?□ □
Are your teeth sensitive? _____ □ □
Do you feel pain when your teeth come in contact with:
Hot foods or liquids? _____ □ □
Cold foods or liquids? _____ □ □
Do you take fluoride supplements? □ □
Are you dissatisfied with the appearance of your teeth? □ □
How often do you brush? _____
How often do you floss? _____

Yes/ No

Do you clench or grind your jaws frequently? _____ □ □
Do your jaws ever feel tired? _____ □ □
Does your jaw get stuck so that you can't open freely? _ □ □
Does it hurt when you chew or open wide to take a bite? □ □
Do you have earaches or pain in front of the ears? ____ □ □
Do you have any jaw symptoms or headaches upon waking in the morning? _____ □ □
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? _____ □ □
Do you take medications or pills for pain or discomfort (pain relievers, muscles relaxants, antidepressants)? _____ □ □
Do you have temporomandibular(jaw) disorder (TMD)? □ □
Do you have pain in the face, cheeks, jaws, joints, throat, or temples? _____ □ □
Have you had any trauma to the jaw? _____ □ □

Patient/Guardian Signature: _____

SHORT PUMP FAMILY DENTISTRY

NEW PATIENT INFORMATION

MEDICAL HISTORY: ***DO YOU CURRENTLY HAVE OR HAVE YOU HAD IN THE PAST? (PLEASE CIRCLE)***

Heart Problems
- Chest Pain
- Shortness of breath
- Blood pressure problem
- Heart Murmur
- Heart valve problem
- Taking heart medication
- Rheumatic fever
- Pacemaker
- Artificial heart valve

Blood Problems
- Easy bruising
- Frequent nosebleeds
- Abnormal bleeding
- Blood disease (anemia)
- Previous blood transfusion

Allergy Problems
- Hay Fever
- Sinus Problems
- Skin Rashes
- Taking allergy medicine
- Asthma

Intestinal Problems
- Ulcers
- Weight gain or loss
- Special diet
- Constipation/Diarrhea
- Kidney or bladder problems

Bone or Joint Problems
- Arthritis
- Back or neck pain
- Joint replacement

Diabetes
- Urinate more than 6 time/day
- Thirsty or mouth is dry
- Family history of diabetes

Fainting Spells, Seizures or Epilepsy
Strokes
Frequent or severe headaches
Thyroid Problems
Persistent cough or swollen glands

Cancer/Tumor : _____

Do you drink alcohol? Y / N
If so, how much? _____

Do you smoke? Y / N
If so, how much? _____

Hepatitis, jaundice or liver trouble
Herpes or other STD
HIV-positive/AIDS
Tuberculosis or other respiratory disease

Glaucoma
Do you wear contact lenses? Y / N

History of head injury
History of alcohol or drug abuse

Premedications required by physician
_____

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

Are you allergic or have you reacted adversely to any of the following? (Please circle)

Local anesthetics "Novocaine"
Penicillin or 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
Other _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: (PRESCRIPTION AND OVER-THE-COUNTER)

_____

_____

_____

Women (Please circle)

Currently taking contraceptives or other hormones

Currently pregnant
If so, expected delivery date: _____

Currently nursing

Have you reached menopause: _____

If so, do you have symptoms _____

Patient/Guardian Signature: _____

Date: _____