PATIENT INFORMATION

Welcome to Sabino Hills Family Dentistry. 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:______________________________________ Date of birth:__________________ Sex:_________ Age:________

Home address:_______________________________________ City:___________________ State:___________ Zip:________

Billing Address (*if different*)_____________________________ City:___________________ State:___________ Zip:________

Home phone:____________________ Cell:____________________ Email:____

SS #:__________________ Employer:___________________________________ Preferred Contact Method: Text Phone Email

Spouse's name & phone #:_________________________________ **Emergency phone # (other than spouse)**:___________________

Primary dental insurance:___________________________________ Subscriber ID #:___________________________________

Secondary dental insurance:_________________________________ Subscriber ID #:___________________________________

Subscriber's name:____ Date of birth:__________________ SS #:________________

Name of your medical doctor:_________________________________ Date of last visit to medical doctor:_______________________

Name of previous dentist:___________________________________ Date of last visit to dentist:_____________________________

How did you hear about us? Online Mailer Referred by:______________________ Other:___________________________

DENTAL HEALTH HISTORY

	YES	NO
Are you apprehensive about dental treatment? ________________	☐	☐
Have you had problems with previous dental treatment?_________	☐	☐
Do you gag easily?____________________________________	☐	☐
Does food catch between your teeth?_______________________	☐	☐
Do you have difficulty in chewing food?_____________________	☐	☐
Do you chew on only one side of your mouth?_________________	☐	☐
Do your gums bleed when you floss/brush?___________________	☐	☐
Do your gums feel swollen or tender?_______________________	☐	☐
Have you noticed slow-healing sores in or about your mouth?_____	☐	☐
Are your teeth sensitive?_______________________________	☐	☐
What triggers this?___________________________________		
Do you take fluoride supplements?_________________________	☐	☐

	YES	NO
Do you have pain in the face, cheeks, jaw, joints, throat or temples?_	☐	☐
Do you have temporomandibular (jaw) disorder (TMD)?__________	☐	☐
Do you clench or grind your jaws frequently?__________	☐	☐
Do your jaws ever feel tired?_______________________	☐	☐
Have you ever had a blow to the jaw or head?_________	☐	☐
Do you take medication or pills for pain or discomfort? Such as:		
pain relievers, muscle relaxants, antidepressants________	☐	☐
Please rate the condition of your mouth:		
Excellent **Good** **Fair** **Poor**		
Are you dissatisfied with the appearance of your teeth?__________	☐	☐
Would you like to have a straighter smile?___________________	☐	☐
Are you interested in whitening your teeth?__________________	☐	☐

CARIES RISK ASSESSMENT

Please circle if applicable to you

History of cavities/fillings   Eat sugary foods regularly   Drink acidic beverages (i.e. soda, coffee, etc.) regularly

Frequent dry mouth   History of eating disorders   Use of mouth guard/braces

How often do you brush?___________________________ How often do you floss?___________________________

MEDICAL HEALTH HISTORY

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

	YES	NO
Heart problems? ______	☐	☐
Blood pressure problem?______	☐	☐
Heart murmur?______	☐	☐
Taking heart medication?______	☐	☐
Rheumatic fever? ______	☐	☐
Pace maker?______	☐	☐
Artificial heart valve? ______	☐	☐
Blood problems? ______	☐	☐
Abnormal bleeding? ______	☐	☐
Blood disease (anemia)? ______	☐	☐
Ever require a blood transfusion?______	☐	☐
Allergies?______	☐	☐
Asthma?______	☐	☐
Intestinal problems?______	☐	☐
Acid reflux?______	☐	☐
Special diet?______	☐	☐
Bone or joint problems?______	☐	☐
Arthritis?______	☐	☐
Back or neck pain?______	☐	☐
Joint replacement?______	☐	☐
(e.g., knee, total hip, pins, or implants)		
***Premedication required by physician?**______	☐	☐
Diabetes?______	☐	☐
Family history of diabetes?______	☐	☐
Auto immune disease?______	☐	☐
HIV positive/AIDS?______	☐	☐
Hepatitis, jaundice, liver problems?______	☐	☐
Glaucoma?______	☐	☐
Neurological problems?______	☐	☐
Fainting spells, seizures, or epilepsy?______	☐	☐
Stroke(s)?______	☐	☐
Frequent or severe headaches?______	☐	☐
Persistent cough or swollen glands?______	☐	☐
Tuberculosis or other respiratory disease?______	☐	☐
Cancer/tumor?______	☐	☐
Thyroid problems?______	☐	☐
Herpes or other STD?______	☐	☐
Do you drink alcohol?______	☐	☐
If so, how much?______		
Do you smoke or chew tobacco?______	☐	☐
If so, how often?______		
History of alcohol or drug abuse?______	☐	☐

During the past 12 months, have you taken any of the following?

	YES	NO
Blood thinners (e.g. Coumadin)?______	☐	☐
Insulin, Orinase, or similar drug?______	☐	☐
Medication for Osteoporosis?______	☐	☐
Aspirin?______	☐	☐
Nonprescription drugs/supplements?______	☐	☐

PLEASE LIST ALL MEDICATIONS & THE DOSAGE YOU HAVE TAKEN IN THE PAST 3 MONTHS:

______

______

______

______

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

	YES	NO
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:______	☐	☐

______

WOMEN	**YES**	**NO**
Are you taking contraceptives or other hormones? ______	☐	☐
Are you pregnant? ______	☐	☐
If so, expected delivery date:______		
Are you nursing? ______	☐	☐
Have you reached menopause?______	☐	☐
If so, do you have any symptoms?______		
______		

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

______

______

PATIENT/PARENT SIGNATURE:______

DATE:______