Ocean View Dental

PATIENT INFORMATION

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

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents names _____

Home phone _____Work phone _____Cell phone _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

Email_____

Spouse's name _____ Spouse's employer _____

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

INSURANCE INFORMATION:

DENTAL INSURANCE ❑ Not covered by dental insurance

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

Subsciber ID_____ _____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Subsciber ID_____

Spouse's birthday _____ Social Security number _____

MEDICAL INSURANCE ❑ Not covered by medical insurance

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

Subsciber ID_____ _____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's medical insurance company _____ Group number _____

Subsciber ID_____ _____

Spouse's birthday _____ Social Security number _____

DENTAL HEALTH HISTORY **PATIENT NAME**

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

- ❑ Are you apprehensive about dental treatment?
- ❑ Have you had any problems with previous dental treatment?
- ❑ Do you gag easily?
- ❑ Do you wear dentures?
- ❑ Does food catch between your teeth?
- ❑ Do you have difficulty chewing your food?
- ❑ Do you chew on only one side of your mouth?
- ❑ Do you avoid brushing any part of your mouth because of 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 or about your mouth?
- ❑ Are your teeth sensitive?
- ❑ Do you feel pain when eating hot foods or liquids?
- ❑ Do you feel pain when eating cold foods or liquids?
- ❑ Do you feel pain when eating sweet foods or liquids?
- ❑ Do you feel pain when eating sour foods or liquids?
- ❑ Do you take fluoride supplements?
- ❑ Are you dissatisfied with the appearance of your teeth?
- ❑ Do you prefer to save your teeth?
- ❑ Do you want complete dental care?
- ❑ Does your jaw make noise so that it bother you or others?
- ❑ Do you clench 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 the front of the ears?
- ❑ Do you have any jaw symptoms or headaches upon waking up in the moring?
- ❑ Does jaw pain or discomfort affect your appetite, sleep, or daily routine?
- ❑ Do you find jaw pain or discomfort extremely frustrating or depressing?
- ❑ Do you take medications or pills for pain or discomfort?
- ❑ Do you have temporomandibular (jaw) disorder (TMD)?
- ❑ Do you have pain in the face, cheeks, jaws, joints, throat, or temples?
- ❑ Are you unable to open you mouth as far as your want?
- ❑ Are you aware of an uncomfortable bite?
- ❑ Have you had a blow to the jaw (Trauma)?
- ❑ Are you a habitual gum chewer or pipe smoker?
- ❑ How often do you floss? _____
- ❑ How often do you brush? _____

MEDICAL HEALTH HISTORY PATIENT NAME _____

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

Heart Problems:

- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Taking heart medication
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker

Blood problems:

- ❑ Easy brusing
- ❑ Frequent nose bleeds
- ❑ Abnormal bleeding
- ❑ Blood disease (Anemia)
- ❑ Ever require a blood transfusion

Allergy Problems:

- ❑ Hay fever
- ❑ Sinus problems
- ❑ Skin rashes
- ❑ Taking allergy medication
- ❑ Asthma

Intestinal Problems:

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

Bone or Joint Problems:

- ❑ Arthritis
- ❑ Back or neck pain
- ❑ Joint replacement
- ❑ Fainting spells seizures or epilepsy
- ❑ Stroke
- ❑ Frequent or severe headaches
- ❑ Thyroid problems
- ❑ Persistent cough or swollen glands
- ❑ **Premedications required by physician**
- ❑ Cancer or tumor
- ❑ Diabetes
- ❑ Urinate more than 6 times a day
- ❑ Thirsty or mouth is dry much of the time
- ❑ Family history of diabetes
- ❑ Hepatitis, jaundice, or liver trouble
- ❑ Herpes or other STD
- ❑ HIV-positive/AIDS
- ❑ Glaucoma
- ❑ DO you wear contact lenses
- ❑ History of head injury
- ❑ Epilepsy or other neurological disease
- ❑ History of alcohol or drug abuse
- ❑ Tuberculosis or other respiratory disease
- ❑ Do you smoke or use chewing tobacco?
  ❑ yes ❑ no
  If so how much? _____
- ❑ Do you drink alchohol
  If so how much? _____

(Please check any that apply)

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

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

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives
- ❑ Have you reached menopause?
  If so, do you have any symptoms? Please list below:

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Digitalis or drugs for heart trouble
- ❑ Natural remedies
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Nonprescription drug/supplements
- ❑ Other

Please list current Medications if not listed above:
Use back of page if necessary

_____
_____

_____

_____

Name of your last dentist:_____

Date of last visit to dentist: _____

Name of your physician:_____

Date of last visit to 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

_____

Dr.'s signature _____ Date_____