FILSON GENTLE DENTISTRY

PATIENT NAME _____ DATE OF BIRTH _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CELL PHONE # _____ E-MAIL ADDRESS _____

Current Health

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

AIDS/HIV Positive	○ Yes ○ No	Radiation Treatment	○ Yes ○ No	Alzheimer's Disease	○ Yes ○ No
Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Drug Addiction	○ Yes ○ No
Hepatitis B or C	○ Yes ○ No	Anemia	○ Yes ○ No	Emphysema	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	Arthritis	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No
High Cholesterol	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Asthma	○ Yes ○ No	Fainting/Dizziness	○ Yes ○ No
Sinus Trouble	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Leukemia	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No
Stroke	○ Yes ○ No	Bruise Easily	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Tuberculosis	○ Yes ○ No	Cold Sores	○ Yes ○ No	Heart Murmur	○ Yes ○ No
Heart Pacemaker	○ Yes ○ No	Ulcers	○ Yes ○ No	Heart Disease	○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes _____

Family History:

Stroke ○ Yes ○ No If yes _____

Heart Disease ○ Yes ○ No If yes _____

Diabetes ○ Yes ○ No If yes _____

Gum Disease ○ Yes ○ No If yes _____

Women: Are you ...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contracetptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other allergy not listed above: ○ Yes ○ No If yes _____

Do you use controlled substances? ○ Yes ○ No If yes _____

Are you under a physician's care now? ○ Yes ○ No If yes _____

Doctor/Clinic ○ Yes ○ No If yes _____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes _____

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medicatoins containing bisphosphonates? ○ Yes ○ No If yes _____

Do you use tobacco? ○ Yes ○ No If yes _____

Additional comments _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardinan

X _____ Date: _____

Dental History

Pain around your ears?	○ Yes ○ No	Clench or grind (possibly at night?)	○ Yes ○ No
Aware of any swelling or lump in your mouth?	○ Yes ○ No	Gums bleed when brushed?	○ Yes ○ No
Dissatisfied with your teeth or their appearance?	○ Yes ○ No	Feel you will eventually wear dentures?	○ Yes ○ No
Have any dental fears?	○ Yes ○ No	Sleep Apnea?	○ Yes ○ No
Hear popping, clicking or snapping when chewing?	○ Yes ○ No	Any nasal obstruction?	○ Yes ○ No
Avoid any part of your mouth when brushing?	○ Yes ○ No	Had a reaction to local anesthetic?	○ Yes ○ No
Had any teeth removed?	○ Yes ○ No	How long have these teeth been missing? _____	
Teeth sensitive to heat?	○ Yes ○ No	Teeth sensitive to cold?	○ Yes ○ No
Teeth sensitive to sweets?	○ Yes ○ No	Teeth sensitive to biting pressure?	○ Yes ○ No

HOW DID YOU HEAR ABOUT OUR PRACTICE? (Please circle)

Radio - Flyer - Billboard - Internet - Website - Facebook - Twitter - Sign - Yellow Pages

Patient Referral_____ Other_____

Would you be interested in sedation dentistry? ○ Yes ○ No

Marital Status S_____ M_____ D_____ W_____

Responsible Party_____ Spouse_____

Employer _____ Employer _____

Occupation_____ Occupation_____

Work Phone _____ Work Phone _____

SS# _____ SS# _____

Emergency Contact _____ Phone Number_____