



DONALD TAYLOR / dds, fagd & ASHLEY STRICKLAND / dds

Date.....

Please Print **general information**

PATIENT NAME Last..... First..... Nickname.....

DATE OF BIRTH..... MALE FEMALE Married Single Child Other HOW DID YOU HEAR ABOUT OUR PRACTICE?.....

ADDRESS.....

PHONE Home..... Work..... Cell.....

EMAIL..... HOW DO YOU PREFER TO BE CONTACTED? Email Phone: ___home ___work ___cell

SOCIAL SECURITY NUMBER (for insurance purposes)..... LICENSE NUMBER.....

EMERGENCY CONTACT 1 Name..... Relationship to you..... Phone.....

EMERGENCY CONTACT 2 Name..... Relationship to you..... Phone.....

INSURED OR RESPONSIBLE PARTY INFORMATION:

NAME..... Is insured an existing patient? Yes No Relationship to patient.....

ADDRESS.....

PHONE Home..... Work..... Cell.....

DATE OF BIRTH..... SOCIAL SECURITY NUMBER (for insurance purposes).....

INSURED'S EMPLOYER NAME..... EMPLOYER PHONE.....

EMPLOYER ADDRESS.....

INSURANCE PLAN NAME..... ID #..... GROUP #.....

ADDRESS..... PHONE.....

Please Print **medical history**

DO YOU HAVE, OR HAVE YOU EVER HAD:

- Allergic reaction to: ___ aspirin, ibuprofen, or acetaminophen ___ penicillin ___ erythromycin ___ tetracycline ___ codeine ___ local anesthetic ___ fluoride ___ metals (gold, nickel) ___ latex ___ Other.....
- Anemia
- Arthritis
- Artificial Joints
- Artificial Heart Valve
- Asthma
- Blood Disease
- Blood Pressure: ___ High ___ Low
- Cancer: _____ ___ Radiation ___ Chemotherapy
- Cyst or abnormal growth
- Diabetes
- Depression
- Digestive Disorders
- Dizziness
- Epilepsy / Seizures
- Fainting
- Glaucoma
- Head Injury
- Heart Disease
- Hepatitis
- HIV / AIDS
- Hives or skin rash
- Jaundice
- Kidney Disease
- Liver Disease
- Mental or Nervous Disorders
- Osteoporosis, Osteopenia, Paget's Disease Medications.....
- Pacemaker
- Respiratory: ___ COPD ___ Emphysema
- Sinus Problems
- STD
- Stomach Problems / Acid Reflux
- Stroke
- Thyroid or Parathyroid Disease
- Tuberculosis

HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH? Excellent Good Fair Poor

FEMALES: ARE YOU PREGNANT, OR MIGHT YOU BE? YES Due Date NO

DO YOU USE TOBACCO? YES What type? How much or how often? NO

LIST ANY MEDICATIONS, HERBAL SUPPLEMENTS, AND/OR VITAMINS YOU ARE TAKING:

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT, IMPENDING SURGERY, OR OTHER HEALTH ISSUES YOU CURRENTLY HAVE:

REFERRED BY..... HOW WOULD YOU RATE THE CONDITION OF YOUR MOUTH? Excellent Good Fair Poor

PREVIOUS DENTIST..... HOW LONG WERE YOU A PATIENT?.....months / years

MOST RECENT DENTAL EXAM...../...../..... MOST RECENT X-RAYS...../...../..... MOST RECENT DENTAL TREATMENT (other than a cleaning)...../...../.....

HOW OFTEN DO YOU ROUTINELY SEE YOUR DENTIST? Every 3 months Every 4 months Every 6 months Every 12 months Not routinely

WHAT IS YOUR IMMEDIATE CONCERN?

PLEASE ANSWER YES OR NO TO EACH OF THE FOLLOWING QUESTIONS:

PERSONAL HISTORY YES NO

- 1. Are you fearful of dental treatment? If yes, rate on a scale of 1 - 10 (ten being very fearful):
2. Have you had an unfavorable dental experience?
3. Have you ever had complications from past dental treatment?
4. Have you ever had trouble getting numb or reactions to local anesthetic?
5. Did you ever have braces, orthodontic treatment or your bite adjusted?.....
6. Have you had any teeth removed?

SMILE CHARACTERISTICS

- 7. Is there anything about the appearance of your teeth that you would like to change?.....
8. Have you ever whitened (bleached) your teeth?
9. Are you self-conscious about your teeth?
10. Have you been disappointed with the appearance of previous dental work?

BITE & JAW JOINT

- 11. Do you have any problems chewing gum?.....
12. Do you have any problems chewing bagels or other hard foods?
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?
14. Are your teeth crowding or developing spaces?
15. Do you have more than one bite, or do you clench (squeeze) to make your teeth fit together?
16. Do you have any problems with sleep in general, or wake up with an awareness of your teeth?.....
17. Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)?
18. Do you have tension headaches or sore teeth?
19. Do you wear, or have you ever worn, a bite appliance?

TOOTH STRUCTURE

- 20. Have you had any cavities in the past 3 years?.....
21. Do you have a dry mouth?
22. Are any teeth sensitive to hot, cold, biting or sweets?
23. Have you ever had a toothache, cracked filling, or a broken, chipped or cracked tooth?
24. Do you avoid brushing any part of your mouth?
25. Do you feel or notice any holes (pitting) in your teeth?

GUM & BONE

- 26. Have you ever been diagnosed or treated for periodontal (gum) disease?.....
27. Have you ever experienced gum recession?
28. Is there anyone with a history of periodontal disease in your family?
29. Do your gums bleed when brushing, flossing or eating?
30. Are your teeth becoming loose?
31. Have you ever noticed an unpleasant taste or odor in your mouth?
32. Have you experienced a burning sensation in your mouth?

I consent to dental and oral surgical procedures deemed necessary or advisable, including the use of local anesthetic; I will assume responsibility for fees associated with these procedures. To the best of my knowledge, all information I have provided is correct. I commit to informing Dr. Taylor or Dr. Strickland of any changes to my health at my next appointment.

PATIENT SIGNATURE DATE DOCTOR SIGNATURE..... DATE.....