PATIENT INFORMATION SHEET

Date:______________________How did you hear about us?:☐Google ☐Patient/relative __________☐Other__________

Patient's Name:___________________________Preferred Name: ___________________________

SSN: ____________________ Birthdate:____________________Preferred Language: _______________

Mailing Address: City/ST/Zip_______________________

City/ST/Zip:_______________________

___________________________Cell #_________________________________Sex: M F

Marital Status: M S W D__________ Email:

______________________________Occupation:______________________________________

Emergency Contact Name________________________

___________________________ _________________________

Street Address____

Home Phone #:

Employer: Work Phone:__

Relationship: Emergency Contact Number

Have you provided up to date dental insurance to us? Y ☐ N ☐

Insurance Co __________________________________ Member ID# ____________________________

DENTAL HISTORY

Date of last dental visit? ____________________ Last Dentist seen?

____

How often do you brush? ___________Floss? ____________Reason for todays visit?_________________

Are you interested in our teeth whitening? Y ☐ N ☐

Do you authorize your child to receive fluoride? Y ☐ N ☐

Have you ever experienced an adverse reaction during or in conjunction with anesthesia or a medical procedure? Y ☐ N ☐

Do you have an allergy to latex? Y ☐ N ☐

Other information about your dental health or previous treatment:

____

Have you had problems with any of the following?

If none of these apply, please check here: ☐

☐ Bad breath

☐ Bleeding gums

☐ Sores/growths in mouth

☐ Clicking or popping jaw

☐ Food collection between teeth

☐ Grinding or clenching teeth

☐ Sensitivity to sweets

☐ Loose teeth or broken fillings

☐ Periodontal treatment

☐ Sensitivity to biting

☐ Sensitivity to hot/cold

OTHER:

MEDICAL HISTORY

Physician's name___________________________________Date of last visit ______________________

Are you currently under a physician's care? ☐Y ☐N

If yes, please describe ____ _

In the past two years, have you been admitted to a hospital or needed emergency care? ☐Y ☐N If yes, give approximate date and explain

Have you ever had any complications following dental treatment? ☐Y ☐N
If yes, please explain ____

Women: Are you pregnant? ☐Y ☐N Nursing? ☐Y ☐N Taking birth control pill? ☐Y☐N Is

patient currently taking any medications? ☐Y ☐N If yes, list all in the space below.

____

Does patient have any drug allergies? ☐Y ☐N If yes, please list medications and the allergic reaction.

____

Does patient have any allergy to anesthetic or epinephrine? ☐Y ☐N

Family History of Oral Cancer? Y N

Electronic devices i.e. pacemaker, internal tens unit, cochlear implant etc.:Y☐ N☐
If yes, which device_____________________________________

If you have ever had any of the following conditions, please check:

If none of these apply, check here: ☐

☐ AIDS/HIV Positive	☐ Psychiatric Care	☐ Heart surgery	☐ Anemia
☐ Glaucoma	☐ Arthritis/ Rheumatism	☐ Respiratory disease	☐ Heart murmur
☐ Rheumatic fever	☐ Artificial joints	☐ Heart problems	☐ Shingles
☐ Asthma	☐ Shortness of breath	☐ Atopic/ Allergy prone	☐ Skin rash
☐ Hemophilia/bleeding	☐ Herpes	☐ Blood disease	☐ Hepatitis
☐ Stroke	☐ Cancer	☐ High blood pressure	☐ Jaw pain
☐ Chemotherapy	☐ Kidney disease	☐ Thyroid problems	☐ Liver disease
☐ Tobacco habit	☐ Circulatory Disease	☐ Material allergies	☐ Tonsilitis
☐ Tuberculosis	☐ Mitral valve prolapse	☐ Ulcer/ Colitis	☐ Diabetes
☐ Nervous problems	☐ Epilepsy	☐ Other- please describe:	

If there was one thing you could change about your smile, what would it be?

☐ Whiter

☐ Straighter

☐ Nothing

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate dental treatment. If there is any change in my medical status, I will inform the dentist. I consent to have TimberRidge Dental provide me with dental treatment.

Signature of Patient/Guardian:________________________________Date ________________________