AZ Cosmetic & Family Dentistry: Patient Information, Health History

Patient Name: ______________________________ DOB: ____________

Address: ______________________ City: ______________ State: __________ Zip: __________

Preferred name (Nickname): ______________________________ Sex: M / F

Phone Number(s): Home: ______________ Work: ______________ Cell: ______________

Email Address: ____

SSN: ______________ Emergency contact name and number: ______________________

If you are completing this form for another person, what is your relationship to that person?

Your Name: ______________________ Relationship: ______________________

How did you hear about us? ______________________________________

How would you like to be contacted for appointment reminders? (**Circle all that apply**.)

Home phone   Work phone   Cell phone   Email

Name of Physician: ______________________________ Phone: ______________

Name of previous Dentist: ______________________________ Last visit: ______________

HEART PROBLEMS

Chest Pain □ Yes □ No   Shortness of Breath □ Yes □ No   Blood Pressure Problems □Yes □ No

Heart Murmur □ Yes □ No   Heart Valve Problem □ Yes □ No   Taking Heart Medication □Yes □ No

Rheumatic Fever □ Yes □ No   Pacemaker □ Yes □ No   Other: ______________

BLOOD PROBLEMS

Easy Bruising □Yes □ No   Frequent Nose Bleeding □ Yes □ No

Abnormal Bleeding □ Yes □ No   Blood Disease (anemia) □ Yes □ No

ALLERGY PROBLEMS

Hay Fever □ Yes □ No   Sinus Problems □ Yes □ No   Skin Rashes □ Yes □ No

Asthma □ Yes □ No   Taking Allergy Medication □ Yes □ No

INTESTINAL PROBLEMS

Ulcers □ Yes □ No   Weight Gain or Loss □ Yes □ No

Constipation □ Yes □ No

BONE OR JOINT PROBLEMS

Arthritis □ Yes □ No   Back or Neck Pain □ Yes □ No

Joint Replacement □ Yes □ No   Pins or Metal Rods □ Yes □ No

PLEASE CHECK ALL THAT APPLY:

Fainting/Seizures □ Yes □ No   Diabetes □ Yes □ No   HIV Positive/AIDS □ Yes □ No

Tuberculosis/Respiratory □ Yes □ No   Cancer/ Tumor □ Yes □ No   Glaucoma □ Yes □ No

Hepatitis/Jaundice/Liver □ Yes □ No   Herpes □ Yes □ No   Psychiatric problems □ Yes □ No

Hospitalized last 5 yrs □ Yes □ No   Other: ______________________________

Current Medications: ____

____

Women Only: Are you :

Pregnant ? ◻ Yes ◻ No If yes , Number of weeks ?: _______________

Taking birth control pills or hormone replacement? ◻ Yes ◻ No Nursing ? ◻ Yes ◻ No

ARE YOU ALLERGIC TO THE FOLLOWING?

Local Anesthetics ◻ Yes ◻ No Penicillin or other antibiotics ◻ Yes ◻ No

Sulfa Drugs ◻ Yes ◻ No Barbiturates, sedatives ◻ Yes ◻ No

Codeine ◻ Yes ◻ No

Other Allergies:____

DENTAL HISTORY

Are you having any discomfort? ◻ Yes ◻ No

Any sensitivity to hot, cold, sweets, chewing? ◻ Yes ◻ No

Does dental treatment make you nervous? ◻ Yes ◻ No

Are your teeth turning darker or yellow? ◻ Yes ◻ No

Is your mouth dry? ◻ Yes ◻ No

Does food or floss catch between your teeth? ◻ Yes ◻ No

Do you use a CPAP machine? ◻ Yes ◻ No Like / Don't Like

Do you find yourself tired by mid-day? ◻ Yes ◻ No

Do you find yourself gasping for air during sleep? ◻ Yes ◻ No

Have you experienced any of the following problems?

Snoring Problems ◻ Yes ◻ No Bleeding Gums ◻ Yes ◻ No

Bad Breath ◻ Yes ◻ No Grinding/Clenching ◻ Yes ◻ No

Have you ever had any orthodontic treatments/ procedures? If yes, please describe and were you pleased with the results:

____

____

If I could change my teeth I would make them:

_____ Whiter _____ Close Spaces _____ Replace Stained Front Fillings _____ Change Silver Fillings to white

_____ Repair Chipped Teeth Other: ____

How many times a day do you brush your teeth ?____________ How often do you floss ?______________

What type of tooth brush do you use? Manual / Electric

On a scale of 1 to 10 (10 being the best) How would you rate your smile? ___________

Would you be interested in learning more about Invisalign (clear braces)? ___________

I acknowledge that the above information is correct to the best of my knowledge and any changes in health status will be reported to this office. I have read and understand this form.

Patient/Parent: ____ Date: ______________