oldorchard smiles
growing beautiful smiles

*Welcome to our practice!*

**Today's Date**: ______________________

**Name**: ________________________________________ I prefer to be called: ______________________

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ other ________

If minor, name and relationship of person filling out this form: ____________________________

Gender: ☐ Male ☐ Female   Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ separated

Birthdate ___ /___ / ___   Age: ________   Social Security # _______ - ______ - ________

Address ________________________________________________________

City ______________________________ State ________ Zip __________

Home Phone _______________ Cell phone________________

Email __________________________

**Occupation** ____________________ Employer _______________ Work phone ____________________

**How were you referred to our office?** ____________________________________

**Other family members seen by us:** ______________________________________

**Responsible Party's Name** (if different from above) ____________________________

Relationship to Patient _____________________________________________

Address ________________________________________________________

City ______________________________State ________Zip__________

Home Phone ________________ Work _____________ Cell _____________

Email ____________________________ Social Security Number _______ - _____ - _______

**Do you have dental insurance?** ☐ No ☐ Yes   If yes, please fill out top portion of *Insurance Form*.

**Person to contact in an emergency**:

Name______________________________ Phone Number _________________________

Relationship to Patient ___________________________________

*Excellent communication is a very important part of providing quality care. To assist us in this effort, please complete the following information*:

We normally contact our patients between 9:00am and 6:00 pm. What is the best method to contact you?_________________________________________

If you are unavailable at the time we try to contact you, may we leave information on your voicemail, answering machine or email? Please check all that apply: ☐ Home ☐ Work ☐ Cell

If you are unavailable at the time we contact you, may we leave a message with another person?

☐ No ☐ Yes, with: ____________________________

*PLEASE CONTINUE ON BACK SIDE OF THIS FORM*

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# Dental & Medical History

**Why have you come to the dentist today?** ______________________

______________________________________

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? ______________________

Do you have mobility in your teeth? ❑ Yes ❑ No

Do you still have wisdom teeth? ❑ Yes ❑ No

Previous / Present Dentist: ____________________ Last Visit Date: ________

(Please Circle)

Would you like fresher breath? ❑ Yes ❑ No Whiter teeth? ❑ Yes ❑ No

**Are you happy with the way your smile looks?** ❑ Yes ❑ No

If not, what would you change? ______________________________________

______________________________________

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: ______________________________________

Address: ______________________________________
Street

______________________________________
City State Zip

Phone #: (___)________________ Date of last visit: ________________

**Your current physical health is:** ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: ______________________________________

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you ever taken Phen-Fen, Redux or Pondimin? ❑ Yes ❑ No

**For Women:** Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: _________ Are you nursing? ❑ Yes ❑ No

**Do you or have you experienced the following?**

| | | | | |
|---|---|---|---|---|
| Y N Abnormal Bleeding | Y N Colitis | Y N Hay Fever | Y N Liver Disease | Y N Shingles |
| Y N Alcohol Abuse | Y N Congenital Heart Defect | Y N Headaches | Y N Low Blood Pressure | Y N Sickle Cell Disease |
| Y N Anemia | Y N Diabetes | Y N Heart Attack | Y N Lupus | Y N Sinus Problems |
| Y N Arthritis | Y N Difficulty Breathing | Y N Heart Murmur | Y N Mitral Valve Prolapse | Y N Steroid Therapy |
| Y N Artificial Bones/Joints | Y N Drug Abuse | Y N Heart Surgery | Y N Pacemaker | Y N Stroke |
| Y N Artificial Valves | Y N Emphysema | Y N Hemophilia | Y N Persistent Cough | Y N Thyroid Problems |
| Y N Asthma | Y N Epilepsy | Y N Hepatitis | Y N Psychiatric Problems | Y N Tonsillitis |
| Y N Blood Transfusion | Y N Ever Hospitalized | Y N Herpes | Y N Radiation Treatment | Y N Tuberculosis (TB) |
| Y N Cancer | Y N Fainting Spells | Y N High Blood Pressure | Y N Rheumatic Fever | Y N Ulcers |
| Y N Chemotherapy | Y N Fever Blisters | Y N HIV+/AIDS | Y N Scarlet Fever | Y N Venereal Disease |
| Y N Chicken Pox | Y N Glaucoma | Y N Kidney Problems | Y N Seizures | |

Please list any serious medical condition(s) that you have experienced: ______________________________________

Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No If yes, please list each one: ______________________

______________________________________

**Are you allergic to any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| Y N Aspirin | Y N Codeine | Y N Erythromycin | Y N Latex | Y N Sedatives | Y N Tetracycline |
| Y N Barbiturates | Y N Dental Anesthetics | Y N Jewelry / Metals | Y N Penicillin | Y N Sulfa Drugs | Y N Other |

Please list anything additional that causes allergic reactions: ______________________________________

I affirm that the information I have given is correct to the best of my knowledge.

________________________ ________________________ ________________________
Patient's Signature If minor, Signature of Parent or Guardian Date

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