Jacksonville Family Dentistry

PATIENT INFORMATION

Patient Name: _____ Today's Date: _____ / _____ / _____

__ Male __ Female Marital Status: __ Single __ Married __ Other

Social Security #: _____ / _____ / _____ Date of Birth: _____ / _____ / _____ Age: _____

Home # (____) _____ Work # (____) _____ Ext:_____ Cell # (____) _____

Drivers License #: _____ Email Address: _____@_____

Street Address: _____ City, State Zip _____

If you're completing this form for someone else what is your relationship to that person?

Your name: _____ Relationship: _____

Emergency Contact: _____ Relation: _____ Phone #: (____) _____

HEALTH INFORMATION

Do you have or have you ever had any of the following? Please check all that apply. If none, please check NONE.

__ NONE
__ AIDS / HIV
__ Allergies
__ Aortic Valve Reg
__ Anemia
__ Arthritis
__ Artificial Joints
__ Asthma
__ Blood Transfusion
__ Birth Control
__ Cancer
__ Codeine Allergy
__ Diabetes
__ Dizziness
__ Alcohol / Drug Addiction
__ Epilepsy
__ Fainting
__ Fever Blisters
__ Glaucoma
__ Head Injuries
__ Heart Disease
__ Heart Murmur
__ Hepatitis _____
__ High Blood Pressure
__ Jaundice
__ Kidney Disease
__ Latex Allergy
__ Liver Disease
__ Mitral Valve Prolapse
__ Mouth Ulcers
__ Nervous Disorders
__ Pacemaker
__ Penicillin Allergy
__ Radiation Treatment
__ Respiratory Problems
__ Rheumatic Fever
__ Rheumatism
__ Sexually Transmitted Disease
__ Sinus Problems
__ Stomach Ulcers
__ Stroke
__ Sulfur Allergy
__ Tuberculosis
__ Ulcers
__ Using Blood Thinner
__ Using Methadone
__ Viagra Type Medications
__ Other _____

Have you been admitted to a hospital or needed emergency care during the past five years? __ YES __ NO
If yes, please explain: _____

Are you under the care of a physician now? __ YES __ NO
If yes, please explain: _____

Name of Physician:_____ Phone # (_____) _____

Do you have any health problems not listed above or that need further clarification? __ YES __ NO
If yes, please explain: _____

What medications are you currently taking, including any over the counter and herbal medications?

_____

Have you ever taken/currently taking Bisphosphonates (medications used for osteoporosis and similar diseases)?_____ If yes, please explain: _____

Are you allergic to anything? _____If yes, please explain:_____

WOMEN only: Are you pregnant? __ YES __ NO If yes, Due Date: _____ / _____ / ___

DENTAL HISTORY

Date of your LAST Dental Visit: _____ / _____ / _____ Reason for TODAY'S visit: _____

Have you ever had complications following a dental procedure?	__ YES	__ NO
Do your gums bleed when you brush or floss?	__ YES	__ NO
Are your teeth sensitive to hot / cold / sweets / pressure?	__ YES	__ NO
Do you have dry mouth?	__ YES	__ NO
Do you have / wear a denture or partial	__ YES	__ NO
Have you had any periodontal (gum) treatments?	__ YES	__ NO

JACKSONVILLE
FAMILY DENTISTRY