COMPLETE Dental Care

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www.CompleteDentalCareBurleson.com

Patient Medical Information

Title__________ Last______________________________First______________________________

Address____

City______________________________State______________Zip______________________________

Email____DL#______________

Birth Date___________________________Age____________Marital Status________________Sex______

Home#________________Work#_________________Cell#___________________SSN_______________

Student________________School Name____

How did you hear about our office?____

Person Responsible / Guarantor for Paying Bills

Title_________Last_______________________First__________________Preferred Name____________

Address____

City______________________________State______________Zip______________________________

Email____DL#______________

Birth Date___________________________Age____________Marital Status________________Sex______

Home#________________Work#_________________Cell#___________________SSN_______________

Do you have Primary Dental Insurance? _____Yes _____No
Do you have Secondary Dental Insurance? _____Yes _____No

Insurance Co_________________________Group #___________________ Subscriber ID_________________

Insurance Co Address__________________________________Insurance Co Phone_________________________

Employer Name_______________________Subscriber Last_____________Subscriber First_____________ DOB______

Subscriber Address____

City______________________________State______________Zip______________________________

Relationship to Patient____

Patient Medical Information

Allergic To: (Circle Y for Yes, N for No)							
		Anorexia / Bulimia	Y or N	Epilepsy	Y or N	Mitral Valve Prolapse	Y or N
Amoxicillin	Y or N	Arthritis	Y or N	Fainting Spells / Seizures	Y or N	No Epinephrine	Y or N
Aspirin	Y or N	Asthma / Hay Fever	Y or N	Fever Blisters / Herpes	Y or N	Premedicate	Y or N
Barbiturates / Sleeping Pills	Y or N	Autism	Y or N	Frequent Headaches	Y or N	Infective Endocarditis	Y or N
Codeine / Other Narcotics	Y or N	Birth Control Pills	Y or N	Heart Attack / Stroke	Y or N	Prolonged Bleeding	Y or N
Latex Rubber	Y or N	Blood Clotting Problems	Y or N	Heart Disease / Angina	Y or N	Radiation Treatment	Y or N
Erythromycin	Y or N	Blood Disorders	Y or N	Heart Murmur	Y or N	Rheumatic Fever	Y or N
Iodine	Y or N	Blood Transfusion	Y or N	Heart Valve Replacement	Y or N	Rheumatic Heart Disease	Y or N
Local Anesthetics	Y or N	Bronchitis	Y or N	Hepatitis / Jaundice	Y or N	Sexually Transmitted Disease	Y or N
Metals	Y or N	Cancer / Tumor or Growth	Y or N	Prior Hepatitis	Y or N	Shortness of Breath	Y or N
Penicillin	Y or N	Cardiac Pacemaker	Y or N	High Blood Pressure	Y or N	Sinus Trouble	Y or N
Sulfa Drugs	Y or N	Chest Pain Upon Exertion	Y or N	High Cholesterol	Y or N	Stomach Ulcers	Y or N
Other Allergy? See Med Hx	Y or N	Damaged Heart Valve	Y or N	Hives / Skin Rash	Y or N	Stroke	Y or N
Any known drug allergies?	Y or N	Depression	Y or N	Joint Replacement	Y or N	Thyroid Problems	Y or N
Circle Yes if applicable, No if not		Diabetes	Y or N	Kidney / Bladder Trouble	Y or N	Tuberculosis	Y or N
AIDS / HIV Infection	Y or N	Dry Mouth / Dry Eyes	Y or N	Liver Disease	Y or N	Other contagious disease	Y or N
Alcohol / Drug Abuse	Y or N	Emphysema	Y or N	Low Blood Pressure	Y or N		
Anemia / Leukemia	Y or N	Environmental Allergies	Y or N	Mental Health Problems	Y or N		

(continued on page 2)

Medical Questionnaire *(check if yes)*

Physician Name______________________________ Phone______________

Are you currently under care of a Physician? ☐ If Yes, what is the condition being treated?______________

Have you had any serious illnesses, operation or been hospitalized within the past 5 years? ☐ If Yes, what illness or problem?______________

Are you currently taking any medication (prescription, over the counter, herbal supplements)? ☐ If Yes, what?______________

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Are you taking Bisphosphonates? ☐ Do you use alcoholic beverages? ☐ Do you smoke? ☐

WOMEN ONLY: Are you pregnant? ☐ If Yes, what is your due date?________ Are you currently nursing? ☐ Are you on birth control pills / fertility drugs? ☐

Additional Comments

Any Disease, Condition or Problem not Listed? Please list:______________

Additional Allergies not listed above______________

Additional Comments______________

Dental Information

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name______________ How long have you been a patient there?______________

Date of most recent dental exam:______________ Date of most recent dental x-rays:______________

What is your immediate concern?______________

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)______________

Personal History, Check all that apply:

- ☐ Had an unfavorable dental experience?
- ☐ Had trouble getting numb?
- ☐ Had/Have braces, orthodontic treatment?
- ☐ Had any teeth removed?
- ☐ Had complications from past dental treatment?
- ☐ Had any reactions to local anesthetic?
- ☐ Had my bite adjusted?

Smile Characteristics, Check all that apply:

- ☐ Have I ever whitened (bleached) my teeth?
- ☐ Is there anything about the appearance of my teeth that I would like to change?
- ☐ Have I felt uncomfortable or self conscious about the appearance of my teeth?
- ☐ Have I been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

- ☐ I have problems with my jaw joint
- ☐ I have problems chewing
- ☐ I wear or have worn a bite appliance
- ☐ My teeth are crowding or developing spaces
- ☐ I chew ice, bite my nails, use my teeth to hold objects, or have other oral habits
- ☐ I clench my teeth in the daytime or make them sore
- ☐ I have problems with sleep or wake up with an awareness of my teeth
- ☐ My teeth changed in the last 5 years, become shorter, thinner, or worn

Tooth Structure, Check all that apply:

- ☐ Cavities within past 3 years
- ☐ Food gets caught
- ☐ The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
- ☐ I notice or have holes (pitting or craters on the biting surface of my teeth)
- ☐ I have teeth sensitive to hot, cold, biting, sweets, or I avoid brushing any part of my mouth
- ☐ Grooves or notches on my teeth, chipped teeth, or had a toothache or cracked filling

Gum and Bone, Check all that apply:

- ☐ Gums bleed when brushing or flossing
- ☐ Gum recession
- ☐ Noticed an unpleasant taste or odor in my mouth
- ☐ Experienced a burning sensation in my mouth
- ☐ History of periodontal disease in my family
- ☐ Treated for gum disease or was told I have lost bone around my teeth
- ☐ Have any teeth become loose on their own (without injury), or have difficulty eating an apple

If any of the checked boxes need further explanation, please describe:

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PATIENT SIGNATURE ______________________ DATE ____________

REVIEWED BY: DOCTOR SIGNATURE ______________________ DATE ____________