Alabama 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?

_____

_____

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
Do you use tobacco (smoke, snuff, chew)?	☐ YES	☐ NO