

Soft Touch Dental Care

Patient Name: _____ Sex: F M

How would you prefer our team to address you? _____

Address: _____ City, State, Zip _____

Home Phone: _____ Birth Date: _____

Work Phone: _____ SSN: _____

Cell Phone: _____ Referred By: _____

E-Mail Address: _____ Occupation: _____

Emergency Contact/Phone: _____ Previous Dentist: _____

Dental Insurance Carrier: _____ Employer: _____ Group #: _____ ID#: _____

Policy Holder's Name: _____ Policy Holder's Birth Date: _____

Who is your Primary Care Physician? _____ Physician's Phone Number: _____

Marital Status: _____ Spouse Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Do you need to take an antibiotic premedication prior to your dental appt? Yes No If yes, please explain: _____
- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____
- Have you been treated with Bisphosphonate Drugs? Yes No Name of Med: _____

Women—Are you: Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following? _____

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other—Please explain: _____

- Do you have, or have you had, any of the following? _____
- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Seasonal Allergies <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No | |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No | |
| Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

Soft Touch Dental Care

MEDICAL HEALTH INFORMATION

Have you come to Soft Touch Dental Care for relief of pain? Y / N Explain: _____
 How would you describe your present health? Excellent _____ Good _____ Fair _____ Poor _____ Don't Know _____
 Has there been any change in your general health in the last year? Y / N
 Have you ever had excessive bleeding that required special treatment? Y / N
 Do you have difficulty in healing? Y / N
 Do you snore? Y / N
 Is there a history of diabetes in your family? Y / N
 Are you required to restrict your work or activity in any way? Y / N
 Do you wear contact lenses? Y / N
 Have you ever been treated for a growth / tumor on your body? Y / N
 Would you describe yourself as having a lot of stress? Y / N

DENTAL HEALTH INFORMATION

How would you describe your dental health? Excellent _____ Good _____ Fair _____ Poor _____ Don't Know _____
 Do you think your teeth are affecting your general health? Y / N
 Have you had personal instruction on oral hygiene? Y / N
 Do you feel your present oral hygiene is effective in cleaning your mouth? Y / N
 Are you satisfied with the color of your teeth? Y / N
 Are you satisfied with your smile line? Y / N
 Have you ever been concerned about bad breath? Y / N
 Do you consistently get a bad taste in your mouth? Y / N
 Are you currently using anything for bad breath control? Y / N
 Do your parents have a history of tooth loss from periodontal disease? Y / N
 Do you have difficulty with dry mouth? Y / N
 When and for what reason did you last visit your dentist? _____
 When was your last hygiene appointment? (cleaning / oral cancer exam) _____
 Were your pockets checked at this last appointment? (probing) _____
 Have you ever had x-ray or surgery treatment for a tumor or growth about your head, mouth or lips? Y / N
 Have you ever had an injury to your face or jaw? Y / N
 Have you ever had an acutely sore mouth? Y / N
 Have you ever had any sores in your mouth that are slow to heal? Y / N
 Do you have pain in your teeth from heat, cold or sweets? Y / N
 Have you had swollen areas of the gums? Y / N
 Have you ever had periodontal (gum) treatments? Y / N
 Have you had previous orthodontic treatment (braces)? Y / N
 Have you ever had your teeth ground or your bite adjusted? Y / N
 Have you ever worn a bite plane or other appliance? Y / N
 Do your gums bleed easily? Y / N
 Have you noticed any loose teeth? Y / N
 Have you noticed any change in the position of your teeth? Y / N
 Do you have a click, pop or pain in the area of your jaw joint? Y / N
 Do you have any problems with your jaw joint or do you have TMJ? Y / N
 Do you have difficulty chewing or swallowing? Y / N
 Are you aware of clenching, gritting or grinding your teeth during the day? Y / N
 Are you aware of clenching, gritting or grinding your teeth during the night? Y / N

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____