Soft Touch Dental Care

Patient Name: _____ Preferred Name: _____

Pronouns: _____ Sex: ○F ○M

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 list medications: _____

_____

_____

Do you use tobacco? ○ Yes ○ No If yes, please list: _____

Do you use controlled substances? ○ Yes ○ No If yes, please list: _____

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

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

Comments: _____

(Please complete the reverse side)

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 personal health?	Excellent_____ Good_____ Fair_____ Poor_____ Don't Know _____
Do you have difficulty in healing?	Y / N
Do you snore?	Y / N
Is there a history of diabetes in your family?	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
Are you satisfied with the color of your teeth?	Y / N
Are you satisfied with your smile line?	Y / N
Do you consistently get a bad taste in your mouth?	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 was your last hygiene appointment? (cleaning / oral cancer exam)	_____
Have you ever had an injury to your face or jaw?	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 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?	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 _____

(Please complete the reverse side)