

# Park 56 Dental Group

## Patient Information

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security No. \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Whom may we thank for referring you to our practice? \_\_\_\_\_

## Contact Information

Patient's Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_  
Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Where and when is the best place and time to contact you? \_\_\_\_\_  
In an emergency who shall we contact? \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## Dental Health and Concerns

Date of last dental exam \_\_\_\_\_ Date of x-rays \_\_\_\_\_ Date of last cleaning \_\_\_\_\_

What are your chief concerns and/or reasons for this visit? \_\_\_\_\_

How do you feel about the appearance of your teeth, your gums and your smile? \_\_\_\_\_

Do you have any specific concerns about your dental health and treatment that you would like us to know about?  
\_\_\_\_\_

Please answer Y or N and give details (severity, location...) to any Yes answers in the space that follows below the questions:

Do you routinely take antibiotics (pre-medication) before a dental visit?	Yes	No
Do you experience headaches, migraines, earaches or neck pains?	Yes	No
Do you use tobacco products? Type and amount? _____	Yes	No
Do you consume alcohol? Amount per week _____	Yes	No
Are your teeth sensitive to (please check): ___hot ___cold ___sweets ___pressure?	Yes	No
Do your gums bleed when brushing or flossing?	Yes	No
Have you had any periodontal (gum) problems?	Yes	No
Have you had orthodontic (braces) treatment?	Yes	No
Do you wear removable dental appliances, a night guard or a retainer?	Yes	No
Do you chew on one side or avoid any areas of your mouth? Are you having pain?	Yes	No
Do you experience dry mouth?	Yes	No

Please give details to any Yes answers above: \_\_\_\_\_

How often do you floss? \_\_\_\_\_ Brush? \_\_\_\_\_ Type of Brush \_\_\_\_\_

## Medications

Please list all prescription/non-prescription medication(s) that you are taking and dosages if known. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you taken Fosamax, Actonel or other drugs to treat or prevent osteoporosis? Yes No

Have you taken Pondimin, Redux or Phen-fen? Yes No

## Allergies

Aspirin	Yes	No	Unknown
Local anesthetics	Yes	No	Unknown
Penicillin/antibiotics	Yes	No	Unknown
Sulfa drugs	Yes	No	Unknown
Narcotics/codeine	Yes	No	Unknown
Latex	Yes	No	Unknown

Other allergies \_\_\_\_\_

If you have any allergies, please describe. \_\_\_\_\_

\_\_\_\_\_

**Medical Health and History** Please explain any "Yes" answers to the questions below.

Abnormal bleeding	Yes	No	Unknown	Irregular heartbeat/arrhythmia	Yes	No	Unknown
AIDS or HIV	Yes	No	Unknown	Kidney disease	Yes	No	Unknown
Anorexia/bulimia	Yes	No	Unknown	Liver disease/jaundice	Yes	No	Unknown
Arthritis	Yes	No	Unknown	Mental health disorders	Yes	No	Unknown
Asthma	Yes	No	Unknown	Mitral valve prolapse	Yes	No	Unknown
Blood pressure - High or Low	Yes	No	Unknown	Neurological disorders	Yes	No	Unknown
Blood transfusion	Yes	No	Unknown	Orthopedic replacement-hip/knee/joint/etc.			
Cancer/chemotherapy	Yes	No	Unknown		Yes	No	Unknown
Chemical dependency	Yes	No	Unknown	Osteoporosis	Yes	No	Unknown
Chest pain with exertion	Yes	No	Unknown	Pacemaker/cardiac surgery	Yes	No	Unknown
Chronic pain	Yes	No	Unknown	Persistent swollen glands	Yes	No	Unknown
Congenital heart defect	Yes	No	Unknown	Pregnant	Yes	No	Unknown
Cough producing blood	Yes	No	Unknown	Nursing	Yes	No	Unknown
Cough lasting longer than 3wk	Yes	No	Unknown	Radiation treatment	Yes	No	Unknown
Diabetes	Yes	No	Unknown	Severe/rapid weight loss	Yes	No	Unknown
Type I or II				Sinus trouble	Yes	No	Unknown
Epilepsy and/or seizures	Yes	No	Unknown	Sleep disorder	Yes	No	Unknown
G.E. reflux	Yes	No	Unknown	Stroke	Yes	No	Unknown
Glaucoma	Yes	No	Unknown	Lupus	Yes	No	Unknown
Heart/cardiac disease	Yes	No	Unknown	Thyroid/endocrine disorder	Yes	No	Unknown
Hemophilia	Yes	No	Unknown	Tuberculosis (TB)	Yes	No	Unknown
Hepatitis Type A, B or C	Yes	No	Unknown	Ulcers or other GI disease	Yes	No	Unknown
Immunosuppression	Yes	No	Unknown	Other not listed _____			

Please explain and describe any yes answers to the above questions. \_\_\_\_\_

\_\_\_\_\_

Please list all current or recent medical conditions and/or surgeries and/or current medical treatments. \_\_\_\_\_

\_\_\_\_\_

**Other Information**

Who is your physician? \_\_\_\_\_ Phone ( ) - \_\_\_\_\_

When was your last physical exam? \_\_\_\_\_ Findings \_\_\_\_\_

Are there any concerns you would like the practice staff to know about (insurance, family, accommodations, etc.)? \_\_\_\_\_

\_\_\_\_\_

**Disclosure**

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Office Use Only**

Dentist/hygienist's notes and comments (note and date) \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
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