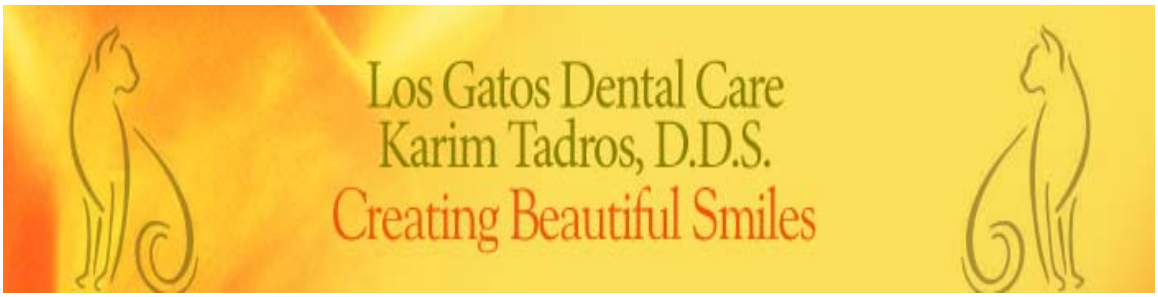

Los Gatos Dental Care
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PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental service. To assist us in serving you, please complete the following forms: The information provided on these forms is important to your dental health. If there have been any changes in you health, please tell us. If you have any questions, do not hesitate to ask.

Patient Name: _____ Date of Birth: _____ Sex: _____ Age: ____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different):_____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ E- mail: _____ DL#: _____

SS# _____ Employer: _____ Business Phone: _____

Spouse's name & Phone #:_____ Emergency Phone # (other than spouse) _____

Primary dental insurance: _____ Group #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of Birth: _____ SS #: _____

Name of your Medical Doctor: _____ Date of last visit to Medical Doctor: _____

Name of previous Dentist: _____ Date of last visit to the Dentist: _____

Referred to us by: _____ _____

DENTAL HEALTH HISTORY

	Yes	No
Are you currently experiencing any discomfort?		
Are you apprehensive about dental treatment?		
Have you had problems with previous dental treatment?		
Do you gag easily?		

How often do you brush? _____ Floss? _____

	Yes	No
Does your jaw make noise so that it bothers you or others?		
Do you clench or grind your jaws frequently?		

Do you wear dentures?
Does food catch between your teeth?
Do you have difficulty in chewing your food?
Do you chew on one side of your mouth?
Do you avoid brushing any part of your mouth due to pain?
Do your gums bleed easily?
Do your gums bleed when you floss?
Do your gums feel swollen or tender?
Have you ever received Periodontal Treatment?
Have you ever noticed slow- healing sores in or about your mouth?

Do your jaws feel tired?
Does your jaw get stuck so that you can't open freely?
Does it hurt when you chew or open wide to take a bite?
Do you have earaches or pain in front of the ears?
Do you have any jaw symptoms or headaches upon awakening in the morning?
Do you have a temporomandibular (jaw) disorder (TMD)?
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?
Are you unable to open your mouth as far as you want?
Are you aware of an uncomfortable bite?

MEDICAL HEALTH HISTORY

Do you have, or have had, any of the following?

Yes No

Are your teeth sensitive to Hot, Cold or Sweets?
Do you take fluoride supplements?
Are you dissatisfied with the appearance of your teeth?
Are you interested in having brighter, whiter teeth?
If you could change anything about your smile, what would it be? _____
Do you prefer to save your teeth?
Do you want complete dental care?
Pre medications required by physician?
Heart Problems
- Chest Pain
- Shortness of breath
- Blood Pressure problem
- Heart Murmur
- Heart valve problem
- Taking heart medication
- Rheumatic fever
- Pacemaker
- Artificial heart valve
- History of Stroke or Heart Attack?

Blood Problems
- Easy bruising
- Frequent nosebleeds
- Abnormal bleeding
- Blood disease (anemia)
- Ever require a blood transfusion?

Allergy Problems
Intestinal Problems
Bone or Joint Problems
- Arthritis
- Back or neck pain
- Joint replacement (e.g. total hip, pins, or implants)

Fainting Spells, Seizures or Epilepsy
Frequent or severe headaches
Thyroid problems
Persistent cough or swollen glands
Cancer/Tumor
Diabetes
Tuberculosis or other respiratory disease
Do you deink alcohol?
Do you smoke?
Hepatitis, jaundice or liver trouble

Yes No

Have you had a blow to the jaw (trauma)?
Are you a habitual gum chewer or pipe smoker?
Are you allergic to, or have you reacted adversely, to any of the following?
Local anesthetics ("Novocaine")
Penicillin or other antibiotics?
Sulfa Drugs?
Barbiturates, sedatives, or sleeping pills?
Aspirin, Acetaminophen, or Ibuprofen?
Codeine, Demerol, or other narcotics?
Reaction to metals?
Latex or rubber dam?
Other, please list below if any
_____
_____

During the past 12 months, have you taken any of the following?
Antibiotics or sulfa drugs?
Anticoagulants(e.g. Coumadin)
High blood pressure medicine
Tranquilizers
Insulin, Orinase, or similar drug
Aspirin
Digitalis or drugs for heart trouble
Nitroglycerin
Cortisone (steroids)
Natural remedies
Non – prescription drugs/supplements
Others(please list below if any)
_____
_____

Women
_____
Are you taking contraceptives or other hormones?
Are you pregnant?
If so, expected delivery date _____
Are you nursing?
Have you reached menopause?
If so, do you have any symptoms?
(List below if any)
_____

Herpes or other STD
HIV- positive/ AIDS
Glaucoma
History of head injury
History of alcohol or drug abuse
Do you have any disease, condition, or problem not listed previously that you feel we should know about?
If so what?
_____

Please list all current medications: _____
_____

Notes: _____

Date: _____ **Patient/ Parent Signature:** _____ **Dentist Initials:** _____