



Los Gatos Dental Care
Karim Tadros DDS Abir Tadros DDS

555 Knowles Dr. Suite 112

Los Gatos CA 95032

Ph: 408-370-7733

Fax: 408-370-7701

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

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? _____

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 drink 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:** _____