christophercooleyDDS

PREVENTATIVE • RESTORATIVE • COSMETIC

PATIENT INFORMATION

Patient's name

Birth date | Social Security number

Patient's address

City | State | Zip

Home phone number | Cell phone number

Patient's employer | Patient's occupation

Business phone number | Ext.

Parent's/spouse's name | Parent's/spouse's employer

Names of other family members

Responsible party's name | Relation to patient

Birth date | Social Security number

Physician's name

Dental insurance company name

Group number | Phone number

Who may we thank for referring you to our office?

WOMEN

Are you pregnant or trying to get pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Are you taking an oral contraceptive?	☐ Yes	☐ No

Are you taking any prescription medication, over-the-counter drugs or vitamins? ☐ Yes ☐ No

Please list

Have you ever taken Phen-Fen or Redux?	☐ Yes	☐ No
Do you take, or have you ever taken, cortisone medication?	☐ Yes	☐ No
Do you use tobacco?	☐ Yes	☐ No
Do you use controlled substances/drugs?	☐ Yes	☐ No
Do your gums bleed?	☐ Yes	☐ No
Are any of your teeth sensitive?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Do you have any discolored teeth that bother you?	☐ Yes	☐ No
Are you happy with the appearance of your teeth?	☐ Yes	☐ No
Does food get caught between your teeth?	☐ Yes	☐ No
How would you rate your overall dental health?	☐ Excellent	☐ Good
	☐ Fair	☐ Poor

Please describe yourself.

- ☐ Male
- ☐ Female
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Widowed
- ☐ Divorced

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Local anesthetics
- ☐ Other

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

- ☐ AIDS/HIV positive
- ☐ Alzheimer's disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/gout
- ☐ Artificial heart valve
- ☐ Artificial joint
- ☐ Asthma
- ☐ Blood disease
- ☐ Blood transfusion
- ☐ Breathing problem
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest pains
- ☐ Cold sores/fever blisters
- ☐ Congenital heart disorder
- ☐ Convulsions
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Easily winded
- ☐ Emphysema
- ☐ Epilepsy or seizures
- ☐ Excessive bleeding
- ☐ Excessive thirst
- ☐ Fainting spells/dizziness
- ☐ Frequent cough
- ☐ Frequent diarrhea
- ☐ Frequent headaches
- ☐ Genital herpes
- ☐ Glaucoma
- ☐ Hay fever
- ☐ Heart attack/failure
- ☐ Heart murmur
- ☐ Heart pacemaker
- ☐ Heart trouble/disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ High blood pressure
- ☐ Hives or rash
- ☐ Hypoglycemia
- ☐ Irregular heartbeat
- ☐ Jaundice
- ☐ Kidney problems
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Lung disease
- ☐ Mitral valve prolapse
- ☐ Pain in jaw joints
- ☐ Parathyroid disease
- ☐ Psychiatric care
- ☐ Radiation treatments
- ☐ Recent weight loss
- ☐ Renal dialysis
- ☐ Rheumatic fever
- ☐ Rheumatism
- ☐ Scarlet fever
- ☐ Shingles
- ☐ Sickle cell disease
- ☐ Sinus trouble
- ☐ Spina bifida
- ☐ Stomach/ intestinal disease
- ☐ Stroke
- ☐ Swelling of limbs
- ☐ Thyroid disease
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Tumors or growths
- ☐ Ulcers
- ☐ Venereal disease

Is there anything you would like to change about your smile?

I authorize payment of my dental insurance benefits directly to Christopher Cooley, DDS and the release of any information concerning my dental treatment to third-party payers or health practitioners.

Patient's/parent's signature | Date