PAGE FAMILY DENTAL

Reviewed by: _____ **Date:** _____

Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Name:
Last _____ First _____
Today's Date: _____
Email: _____
Birthdate: ____ / ____ / ____
Home Address:
_____
_____
Cell:(___)_____ Can we leave a message on this phone? ☐Yes ☐No
May we send you text messages? ☐Yes ☐No
Home:(___)_____ Can we leave a message on this phone? ☐Yes ☐No
Work:(___)_____ext:_____ Can we leave a message on this phone? ☐Yes ☐No
Where is it best to reach you? _____
Do you want to give us permission to speak to anyone else about your treatment or bill?
☐Yes ☐No Who?
_____
Your Employer: _____
Occupation: _____
How did you hear about us? _____
Family members seen here? _____
Previous dentist: _____
Last dental visit? _____
In case of emergency who should we contact?
_____
Relationship: _____
Cell: _____Home: _____

DENTAL

Why have you come to the dentist today?
_____

Are you in pain?	☐Yes	☐No
Ever had gum treatment?	☐Yes	☐No
Jaw problems?	☐Yes	☐No
Do your gums bleed?	☐Yes	☐No
Are you happy with your smile?	☐Yes	☐No
Are your teeth sensitive?	☐Yes	☐No

MEDICAL HISTORY

Physician's name: _____
Phone # (___)_____ Last visit? ____ / ____ / ____
Are you currently under the care of a physician? ☐Yes ☐No
If yes, please explain _____
Do you smoke or use tobacco in any form? ☐Yes ☐No
If yes, what type of tobacco?
Do you take **Fossamax** or **Actonal**? ☐Yes ☐No
Birth Control? ☐Yes ☐No
Are you pregnant? ☐Yes ☐No
Are you taking any prescription, over the counter, or herbal supplement drugs? ☐Yes ☐No
Please list each one:
_____
_____
_____
_____
_____

Are you allergic to or have you had a reaction to any of the following?

Local Anesthetic	☐Yes	☐No
Aspirin	☐Yes	☐No
Penicillin	☐Yes	☐No
Other antibiotic	☐Yes	☐No
Sulfa drugs	☐Yes	☐No
Barbituates, sedative, sleeping pill	☐Yes	☐No
Codeine / Narcotics	☐Yes	☐No
Latex	☐Yes	☐No
Food	☐Yes	☐No
Other		

Have you had any of the following (these may require antibiotic premedication prior to dental work)?

Artificial heart valves	☐Yes	☐No
Artificial joints (Hip / Knee)	☐Yes	☐No
Infective endocarditis	☐Yes	☐No
Damaged valves in transplanted heart	☐Yes	☐No
Congenital heart disease:	☐Yes	☐No
a. Repaired (completely) in last 6 months	☐Yes	☐No
b. Unrepaired, cyanotic CHD	☐Yes	☐No
c. Repaired CHD with residual effects	☐Yes	☐No

MEDICAL HISTORY (continued)

Have you ever had any of the following diseases or medical problems?

Cardiovascular disease	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Congestive heart disease	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Damaged heart valve	☐ Yes ☐ No	Herpes/Cold sores	☐ Yes ☐ No
Heart attack	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No
Heart murmur	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No
Mitral valve prolapse	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Sinus problems	☐ Yes ☐ No
Rheumatic fever	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No
Low blood pressure	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	Psychiatric problems	☐ Yes ☐ No
Abnormal bleeding	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Hemophilia	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Alcohol/Drug abuse	☐ Yes ☐ No	Sickle cell disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Thyroid disorders	☐ Yes ☐ No
Blood transfusion	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Cancer/Chemotherapy	☐ Yes ☐ No	STD's	☐ Yes ☐ No
Radiation treatment	☐ Yes ☐ No	Other-	☐ Yes ☐ No

I believe that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and that Page Family Dental adheres to all HIPPA policies. It is my responsibility to inform this office of any changes in my medical status. I hereby give permission to Page Family Dental to provide routine dental treatment to me. This may include, but is not limited to cleanings, exams, topical and local anesthesia and radiographs. I have received a Notice of the Privacy Practices of Page Family Dental.

Signature _____ Date _____

Nickname _____

Health History Update:

DATE	NO CHANGE	CHANGES	PATIENT INITIAL	STAFF/DR