Sheldon Family
Dental Clinic

Are you allergic or had adverse reactions to:

YES	NO	
☐	☐	Local Anesthetic
☐	☐	Penicillin
☐	☐	Other Antibiotics
☐	☐	Sulfa Drugs
☐	☐	Barbiturates or sedatives
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Seasonal
☐	☐	Food
☐	☐	Metal
☐	☐	Latex

Other_____

Have you been hospitalized or had any surgeries in the past 5 years, if so please describe:

☐ YES ☐NO

_____

_____

Any diseases, conditions, or problems not listed that you think I should know about? If yes, please explain. ☐ YES ☐NO

_____

_____

Reason for today's visit: _____

What is your home's water source? (ex: city, well, rural) _____

DENTAL HISTORY

YES	NO	
☐	☐	Do you have regular dental check ups
		Date of last exam: _____
		Date of last x-rays: _____
☐	☐	Mouth or dental pain
☐	☐	Teeth sensitive to hot or cold
☐	☐	Teeth sensitive to pressure
☐	☐	Lumps or sores in your mouth
☐	☐	Complications with past dental care
☐	☐	Gums bleed when brushing or flossing
☐	☐	Head, neck or jaw injuries

YES	NO	
☐	☐	Jaw discomfort
☐	☐	Fearful of the dentist
☐	☐	Orthodontic care, past or present
☐	☐	Dentures or partials
☐	☐	Oral surgery, past or present
☐	☐	Periodontal or gum treatment
☐	☐	Dry mouth
☐	☐	Do you clench or grind your teeth?
☐	☐	Would you like to change anything about your smile, if so what?

_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services rendered on my behalf or my dependents.

Patient signature:_____

Date:_____

Doctor signature:_____

Date:_____

Sheldon Family Dental Clinic

PATIENT NAME: _____

BIRTH DATE: _____

MEDICAL HISTORY

Please indicate if you have or have had any of the following:

YES	NO	
☐	☐	Artificial heart valve
☐	☐	Pacemaker
☐	☐	Stroke
☐	☐	High blood pressure
☐	☐	Heart attack or heart disease
☐	☐	Angina
☐	☐	Congestive heart failure
☐	☐	Congenital heart defects
☐	☐	Rheumatic fever
☐	☐	Bacterial endocarditis
☐	☐	Heart murmur or mitral valve prolapse
☐	☐	Steroid therapy
☐	☐	Cancer
☐	☐	Radiation therapy
☐	☐	Chemotherapy
☐	☐	Autoimmune disease
☐	☐	Lupus
☐	☐	Rheumatoid arthritis
☐	☐	Arthritis
☐	☐	Organ transplant (ex: heart, kidney)
☐	☐	Spleen removed
☐	☐	Bleeding problems___ or blood disease__
☐	☐	Blood transfusion
☐	☐	Anemia

YES	NO	
☐	☐	HIV/ AIDS
☐	☐	Diabetes: Type I___ Type II___
☐	☐	Thyroid disease
☐	☐	Epilepsy___ or Seizures___
☐	☐	Kidney disease
☐	☐	Hepatitis___ or liver disease___
☐	☐	Asthma
☐	☐	Sinus problems
☐	☐	Fainting___ or dizziness___
☐	☐	Tuberculosis
☐	☐	Lung disease or respiratory problems
☐	☐	Irritable bowel___ or Crohn's disease___
☐	☐	Sleeping disorders___ or snoring___
☐	☐	Heart burn___ or acid reflux___
☐	☐	Sexually Transmitted Disease
☐	☐	Mental Health Condition
☐	☐	Physical disability
☐	☐	Alcohol or drug abuse
☐	☐	Tobacco use: Smoke___ Chew___
☐	☐	Osteoporosis
☐	☐	Bisphosphonate therapy, past/ present (ex: Aredia, Zometa, Fosamax, Actonel, Boniva, Reclast, Prolia, Alendronate)

Women Only:

☐	☐	Pregnant or possibly pregnant Due date:_____
☐	☐	Nursing
☐	☐	Birth control pill

Are you now under the care of a physician? If yes please list doctor's name: ☐ YES ☐NO

Dr. Name_____

Artificial joints: ☐ YES ☐NO

Hip L/R: date placed_____

Knee L/R: date placed_____

Ankle L/R: date placed_____

Other L/R: date placed_____

Are you taking any medications?

If yes please list: ☐ YES ☐NO

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Sheldon Family Dental Clinic

TODAY'S DATE_____

PATIENT INFORMATION

NAME_____ GENDER_____

ADDRESS_____ BIRTHDATE_____

EMAIL_____ CITY/STATE/ZIP_____

CELL PHONE_____ SS#_____

PATIENT EMPLOYER_____ HOME PHONE_____

SPOUSE NAME_____ WORK PHONE_____

IF MINOR, PARENT'S NAME_____ SPOUSE'S EMPLOYER_____

IF MINOR, PARENT'S EMPLOYER_____ EMERGENCY CONTACT NAME_____

EMERGENCY CONTACT PHONE_____

RESPONSIBLE PARTY

NAME_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ HOME PHONE_____

BIRTHDATE_____ WORK PHONE_____

EMPLOYER_____ SS#_____

DENTAL INSURANCE INFORMATION

NAME OF INSURED_____ INSURED ADDRESS_____

INSURED BIRTHDATE_____ SS#_____

NAME OF EMPLOYER_____ INSURED PHONE_____

Do you have secondary insurance? ☐ YES ☐NO

We are honored to have you here today. How did you find us?

☐ Radio ☐ T.V ☐ Newspaper ☐Social Media ☐ Friend/ Family member

☐ Other_____