Patient Information Form

Although in dentistry we primarily treat the mouth and all of its structures, the oral cavity is connected to the rest of the body and acts as a gateway to many of its organ systems. Health problems that you may have or medications that you may be taking could have an important relationship with the dentistry you will receive. Therefore, it is important that you answer all of the pertinent questions so that we can provide you the best possible care. The information you provide is held in confidence. Thank you!

Date_____

What is the reason for your visit today?_____

Who may we thank for referring you to our office?_____

Personal Information

Patient Name_____ D.O.B._____ Age_____ Sex M / F

Address_____ City_____ State_____ Zip _____

Home Phone_____ Work Phone _____ Cell Phone_____

Email address_____ Would you like text or email confirmations? Y / N

SS#_____ Are you …single / married / other? Person responsible for account?_____

Employer_____ Address_____Occupation_____

INSURANCE~ Are you covered by dental insurance Y/N

Name of Policy Holder_____ Phone #_____ D.O.B._____

SS#_____ Employer_____ Insurance Co._____

Member ID#_____ Group #_____ Do you have secondary ins? Y / N

Medical History

Have there been any changes in your health or well being in the last year? Y/N

Have you been hospitalized, had a serious illness or operation/surgery in the last 5 years? Y / N

If so, for what reason_____

Date of last physical exam_____ Are you now under a physician's care? Y / N

Physician name, address, phone #?_____

Do you have an allergy or experience an adverse reaction to any of the following?

Local anesthesia	Penicillin	Amoxicillin	Erythromycin	Keflex	Clindamycin	Sulfa Drugs
Aspirin	Ibuprofen	Food Coloring	Eggs/Milk	Nuts	Latex	Iodine
Acetaminophen (Tylenol)		Codeine or other narcotic		Other_____		

Do you require pre-medication for dental work (cardiac, joint replacement, anxiety or other reason)? Y / N

Women~ Are you or could you be pregnant? Y / N ~ Are you nursing Y / N ~ Do you take birth control pills Y / N

Indicate which of the following you have had, or have at present. Check all that apply.

- ❑ Acid Reflux/GERD
- ❑ AIDS/HIV Positive
- ❑ Allergies
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve/Heart Stent
- ❑ Artificial Joint
- ❑ Asthma
- ❑ Anxiety
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problems
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Contact Lenses
- ❑ Convulsions
- ❑ Coronary Artery Disease
- ❑ Cortisone Medicine
- ❑ COVID-19
- ❑ Depression
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Eating Disorder
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attach/Failure
- ❑ Heart Murmur
- ❑ Heart Pacemaker
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes Simplex/Zoster
- ❑ HPV
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse
- ❑ Neurological Disorders
- ❑ Organ Transplant
- ❑ Osteoporosis
- ❑ 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
- ❑ Sleep Apnea/Snoring
- ❑ Special Diet
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Digestive Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Take Blood Thinners
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

Please describe any conditions listed above._____

Do you…

Consume caffeine Y/N, if so what type: Coffee/ Tea/ Soda / Energy Drinks

Drink alcohol Y/N if so, how many drinks per week?_____

Drink~ Orange Juice Y/N Carbonated beverages Y/N Grapefruit Juice Y/N

PLEASE LIST any prescriptions, vitamins, neutraceuticals, herbal supplements, over-the-counter or street/recreational drugs, CBD or medical marijuana you are currently taking (if you have a current list we can copy it for you)

_____

_____

Dental History

Date of last dental visit_____ Last dental cleaning_____ Last full mouth x-ray_____

Previous dentist's name_____ City _____ State _____

How often do you….Have dental exams?_____Brush?_____Floss?_____

What problems are you having with your teeth, gums, or bite? Please describe. _____

Are any of your teeth sensitive to:

❑ Hot or cold?
❑ Sweets?
❑ Biting or chewing?
❑ Have you noticed any mouth odors or bad tastes?
❑ Do you frequently get cold sores, blisters, or other oral lesions?
❑ Do your gums bleed or hurt?
❑ Have your parents experienced gum disease or tooth loss?
❑ Does food become caught between your teeth?
If yes, where?_____

Do you:

❑ Clench or grind your teeth while awake or asleep?
❑ Bite your lips or cheeks regularly?
❑ Hold foreign objects with your teeth?
(pencils, pipe, pins, nails, fingernails)
❑ Have tired jaws, especially in the morning?
❑ Snore while sleeping?
❑ Like the appearance of your teeth?
❑ Like the color and alignment of your teeth?
❑ Smoke/chew tobacco?
Type (please circle) Cigarettes/Pipe/Cigar/E-Cigarette/Marijuana
If so how much?_____

Have you ever had:

❑ Orthodontic treatment?
❑ Extractions/oral surgery?
❑ Periodontal (gum) treatment?
❑ Your teeth ground or the bite adjusted?
❑ A bite plate or mouth guard?
❑ A serious injury to the mouth or head?
❑ If so, please describe, including cause_____
_____
❑ Dentures/Partials

Have you experienced:

❑ Clicking or popping of the jaw?
❑ Pain (joint, ear, side of face)?
❑ Difficulty in opening or closing the mouth?
❑ Headaches, neck aches, or shoulder aches?
❑ Sore muscles (neck/shoulders)?
❑ Would you like to keep all of your teeth forever?
❑ Do you feel nervous about dental treatment?
If so, what is your biggest concern?_____
_____
❑ Have you ever had an upsetting dental experience?
If yes, please describe_____
_____

Is there anything else about having dental treatment that you would like us to know? Y / N

If yes, please describe._____

_____

Are you interested in/would you like to know more about sedation dentistry? Y / N

Emergency Contact_____Phone #_____ Relationship_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information by needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the office of any change in my health or medications. I will not hold Kevin H. Norige D.M.D. or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form or updates hereafter.

Patient/Guardian Signature_____ Date_____