

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. 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 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.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Take Blood Thinners |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Attach/Failure | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> 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 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 be 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 _____