TROY FAMILY DENTAL

Welcome to Our Practice

We strive to be great relationship builders. One of our top priorities is taking the time to get to know you- offering a listening ear and treating you as a person rather than just another set of teeth to clean and fix. Why? Because in today's fragmented world it might seem that dental health and overall well-being aren't related. We are certain that they are.

Patients Name: _____ Preferred Name: _____

DOB : _____ Gender: *M / F* Date: _____

PATIENT INFORMATION			
Home Address	City	State	Zip
Cell Phone #	***Please circle one:*** Single Married Separated Widow		Your Social Security Number
Work Phone #	Employer		Occupation
If patient is minor we need Mother & Father's Names & Birth date			
Driver's License Number:	Person responsible for account:		
E-mail address	Home Phone #		
Name of spouse *(or parent if minor)*	Spouse's Soc. Sec. #	Work phone #	
EMERGENCY INFORMATION *Name & Telephone of a relative not living with you:*			
How did you hear about our office?			
Reason for this visit?			

DENTAL INSURANCE INFORMATION *(Primary Carrier)*			**SECONDARY DENTAL INSURANCE COVERAGE**		
Name of Insured	DOB	SS#	Name of Insured	DOB	SS#
Insured's employer			Insured's employer		
Insurance Co			Insurance Co		
Insurance Co Address			Insurance Co Address		
Phone #			Phone #		
Group #	Policy #		Group #	Policy #	

DENTAL HISTORY UPDATE

Please Check any of the following problems that apply to you.

	Yes	No
-Sensitivity (hot, cold, sweet)	☐	☐
-Tooth pain or discomfort when chewing	☐	☐
-Headaches, earaches, neck pain	☐	☐
-Jaw joint pain	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath or bad taste in your mouth	☐	☐

On a scale of 1-10, with 10 being the highest rating:

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to youabout your dental visit today?

_____

Do you currently wear a CPAP? _____

If yes, would you be interested in more information about replacing your CPAP?

_____

	Yes	No
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco?	☐	☐

How much? For how long?

If I could change my smile, I would:

-Make it brighter	☐	☐
-Make it straighter	☐	☐
-Close spaces	☐	☐
-Replace black metal fillings with natural, tooth-colored fillings	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?

_____

Are you interested in replacing missing teeth with implants? _____

Last Cleaning: _____

MEDICAL HISTORY UPDATE

Please Check any of the following that apply to you:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Allergies (Seasonal)	☐	☐	Heart Attack/Stroke	☐	☐	Psychiatric Care	☐	☐	Ulcers
☐	☐	Anemia	☐	☐	Heart Disease	☐	☐	Jaundice	☐	☐	Current Smoker/Dipper
☐	☐	Arthritis	☐	☐	Heart Conditions	☐	☐	Jaw Joint Pain	☐	☐	Blood Thinner
☐	☐	Artificial Joints	☐	☐	Heart Murmur	☐	☐	Pacemaker	☐	☐	Past Surgeries
☐	☐	Artificial Heart Valve	☐	☐	Heart Surgery	☐	☐	Pre-Medication	☐	☐	Other:
☐	☐	Asthma	☐	☐	Hepatitis A B C	☐	☐	Radiation (head/neck)	☐	☐	Birth Control Pills
☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐	Respiratory Problems	☐	☐	Breast-feeding
☐	☐	Chemotherapy	☐	☐	Low Blood Pressure	☐	☐	Seizures/Epilepsy	☐	☐	Pregnant
☐	☐	Diabetes	☐	☐	HIV/AIDS	☐	☐	Stomach Problems			
☐	☐	Dental Anxiety	☐	☐	Kidney Disease	☐	☐	Sinus Problems			
☐	☐	Excessive Bleeding	☐	☐	Liver Disease	☐	☐	Severe Headaches			
☐	☐	Emphysema	☐	☐	Mitral Valve Prolapse	☐	☐	Sleep Apnea			
☐	☐	Fever Blisters/ Herpes	☐	☐	Nervous Disorders	☐	☐	Thyroid Disease			
☐	☐	Glaucoma	☐	☐	Oral Cancer	☐	☐	Tuberculosis (TB)			

Do you have any of the following drug allergies?

☐ Aspirin	☐ Penicillin
☐ Codeine	☐ Sulfa
☐ Azithromycin	☐ Tetracycline
☐ Ibuprofen	☐ Tylenol
☐ Latex	☐ Other

Primary care physician & phone number?

_____

Are you under a physician's care? What for?

_____

_____

_____

_____ _____

Patient Signature (Parent of Child) **Date**

_____ _____

Dentist Signature **Date**