SOUTHERN INDIANA DENTAL CARE
Family Dentistry

Patient Information - Please Fill Out Completely

Date _____ Patient Full Name _____ Preferred Name _____

Date of Birth _____ Social Securtiy # _____ Marital Status _____

If patient is a minor, name of Guardian _____ Relationship _____

Name of anyone else with permission to bring minor child to dental appointments and discuss financial options, scheduling, and treatment and their relationship to the minor patient (ex. Grandparents, Step-parent, etc.). _____

_____

Address _____ City_____State_____ Zip _____

Cell Phone # _____ Can we leave a detailed message? Yes____ No___

Home Phone # _____ Can we leave a detailed message? Yes____ No___

Email Address _____ Can we send unencrypted emails? Yes___ No__

Employer _____ Work # _____ Can we leave a detailed message? Yes___No__

Do you have dental insurance? Yes____ No____ Name of Subscriber _____

Name of Physician _____ Name of Previous Dentist _____

Emergency Contact _____ Relationship _____ Phone # _____

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

Dental History

	Yes	No
1. Has a physician or dentist ever told you that you need to take antibiotics before dental treatment?	❑	❑
If yes, please list the reason _____		
2. Please state the reason for your visit today._____		
3. Do you have any discomfort in your mouth now? ……...	❑	❑
4. How long since your last dental visit? _____		
5. Do your gums bleed, feel tender or irritated? ……...	❑	❑
6. Are your teeth sensitive to hot/cold/sweets? ……	❑	❑
7. Does food wedge between certain teeth? ……	❑	❑
8. Do you grind, clench or grit your teeth? ……...	❑	❑
9. Does your jaw ever click or cause pain on opening or closing? ……...	❑	❑
10. Have you ever had gum treatments? ……	❑	❑
11. Do you wear dentures or partials? ……	❑	❑
If yes, are you satisfied with your present dentures? _____		
12. Have you experienced any growths or sore spots in your mouth? ……	❑	❑
13. Do you have an unpleasant taste in your mouth? ……...	❑	❑
14. Do you floss your teeth? ……	❑	❑
15. What would you like to change about your smile if anything? _____		

_____

_____

Continues On Back

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	Yes	No
1. Have you ever been hospitalized, had a major operation or a serious illness? . . . . . If so, what? _____	❑	❑
2. Are you under any medical treatment now? . . . . . If yes, for what condition? _____	❑	❑
3. Have you ever been diagnosed with any of the following conditions? . . . . . **If yes, when and what treatment did you receive?**		
Heart Issue _____	❑	❑
Oral Cancer _____	❑	❑
Other type of cancer _____	❑	❑
Human Papilloma Virus (HPV) _____	❑	❑
Sleep Apnea _____	❑	❑
4. Do you have any artificial joints or valves? . . . . . **If yes, location and placement date** _____	❑	❑
5. Have you ever had or are you currently preparing for organ transplant? . . . . . If yes, which organ and when? _____	❑	❑
6. Have you ever had or are you currently undergoing kidney dialysis?	❑	❑
7. Have you ever had abnormal bleeding problems after a cut or tooth extraction?	❑	❑
8. Do you smoke or use any other tobacco products? If yes, amount per day _____	❑	❑

Allergies: ❑ Aspirin ❑ Codeine ❑ Latex ❑ Novocaine ❑ Penicillin ❑ Sulfa ❑ Other_____

Please check all that apply:

	Yes	No		Yes	No		Yes	No
Acid Reflux	❑	❑	Dry Mouth	❑	❑	Mitral Valve Prolapse	❑	❑
Anxiety	❑	❑	Epilepsy	❑	❑	Pacemaker	❑	❑
Arthritis, Rheumatism . . .	❑	❑	Had a Heart Attack	❑	❑	Psychiatric Care	❑	❑
Asthma	❑	❑	Heart Murmur	❑	❑	Respiratory Disease	❑	❑
Blood Disease	❑	❑	Kidney Disease	❑	❑	Rheumatic Fever	❑	❑
Blood Thinners	❑	❑	Hepatitis Type _____ . .	❑	❑	Stroke	❑	❑
Chemical Dependency . . .	❑	❑	High Blood Pressure	❑	❑	Thyroid Disease	❑	❑
Cholesterol	❑	❑	HIV/AIDS	❑	❑	Tuberculosis	❑	❑
Chronic Pain	❑	❑	Jaw Pain	❑	❑	Tumors	❑	❑
Depression	❑	❑	Kidney Disease	❑	❑	WOMEN: Are you pregnant?	❑	❑
Diabetes.	❑	❑	Liver Disease	❑	❑	Est. date of delivery _____		

Please list **ALL** medicines you take or provide us with a list _____

_____

Signature: _____ **Date:** _____