PATIENT INFORMATION

Welcome to **Kirkland Smiles Dental Care**. We appreciate the confidence you place with us to provide you dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. Please inform us of any changes in your health. If you have any questions, please don't hesitate to ask.

Patient Name:		Today's Date:	
Date of Birth:	Age:	Gender:	
Home Address:			
City:	State:	Zip:	
Billing Address: (if different then above)	City:	State:	Zip:
Cell Phone:	Home Phone:		
Email Address:	Business Phone:		
Employer:	Occupation:		
Spouse's Name:	Spouse's Phone:		
Emergency Contact: (Other then spouse):	Emergency Contact Phone:		
Primary Dental Insurance:	Primary Group Number:		
Secondary Dental Insurance:	Secondary Group Number:		
Subscriber's Name:	Subscriber's Insurance Number:		
Subscriber's Date of Birth:	Name of Medical Doctor:		
Name of Previous Dentist:	Date of Last Visit to Dentist:		
Referred to us by:			

DENTAL HEALTH HISTORY

Do you have or have you had any of the following? (Please check all that apply and answer questions)

- ☐ Pre-medication required by your physician before treatment
- ☐ Apprehension about dental treatment
- ☐ Problems with previous dental treatment
- ☐ Gag easily
- ☐ Wear dentures
- ☐ Food catches between your teeth
- ☐ Difficulty chewing your food
- ☐ Chew on only one side of your mouth
- ☐ Avoid brushing any part of your mouth because of pain
- ☐ Gums bleed easily
- ☐ Gums bleed when flossing
- ☐ Gums feel swollen or tender
- ☐ Notice slow-healing sores in or around your mouth
- ☐ Feel twinges of pain when your teeth come into contact with:
  - ☐ Hot foods or liquids
  - ☐ Cold foods or liquids
  - ☐ Sour foods
  - ☐ Sweet foods
- ☐ Take fluoride supplements
- ☐ Implants in my mouth
- ☐ Drink soda / juice? How often?_____
- ☐ How often do you brush?_____
- ☐ How often do you floss?_____
- ☐ Clench or grind your teeth frequently
- ☐ Jaw symptoms or headaches upon awaking in the morning
- ☐ Jaw gets stuck so that you can't open freely
- ☐ Earaches or pain in front of your ears
- ☐ Jaw pain or discomfort affecting your appetite, sleep, daily routine, or other activities
- ☐ Take medications for pain or discomfort (pain relievers, muscle relaxants, antidepressants)
- ☐ Temporomandibular (jaw) disorder (TMD)
- ☐ Pain in the face, cheeks, jaws, joints, throat, or temples
- ☐ Unable to open your mouth as far as you want
- ☐ Aware of an uncomfortable bite
- ☐ Had a blow to the jaw (trauma)
- ☐ Habitually chew gum
- ☐ Smoke / use pipe / chewing tobacco
- ☐ Feel dissatisfied with the appearance of your teeth
- ☐ Interested in whiter teeth
- ☐ Interested in straighter teeth

MEDICAL HEALTH HISTORY

ALLERGIES: Are you allergic or have you reacted adversely to any of the following?

- ☐ Local anesthetics (Lidocaine / Mepivacaine)
- ☐ Nitrous
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives or sleeping pills
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Acetaminophen
- ☐ Codeine
- ☐ Demerol
- ☐ Metals
- ☐ Latex or rubber dam
- ☐ Other:

If you've had an allergic reaction, what type of reaction?

MEDICATIONS: Are you on any medications? ☐ Yes ☐ No - If yes, please list below.

Name of Medication	Strength & Frequency	Condition Medication Taken For

During the past 12 months, have you taken any of the following medications?

- ☐ Antibiotics or sulfa drugs
- ☐ Anticoagulants (e.g. Coumadin)
- ☐ High blood pressure medicine
- ☐ Tranquilizers or sedatives
- ☐ Insulin, Tolbutamide or similar drug
- ☐ Digitalis, Nitroglycerin or drugs for heart trouble
- ☐ Cortisone (steroids)
- ☐ Aspirin
- ☐ Natural remedies:
- ☐ Nonprescription drug/supplements:
- ☐ Other:

Do you have or have you had any of the following? Please check all that apply.

- ☐ Taking heart medication
- ☐ Heart problems
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Blood pressure problem
- ☐ Heart murmur / valve problem
- ☐ Dizziness
- ☐ Pacemaker
- ☐ Artificial heart valve
- ☐ Rheumatic fever
- ☐ Blood disease problem
- ☐ Easy bruising
- ☐ Frequent nosebleed / abnormal bleeding
- ☐ Anemia
- ☐ Ever require a blood transfusion?
- ☐ Allergy problems/taking allergy medication
- ☐ Hay fever
- ☐ Sinus problems
- ☐ Asthma
- ☐ Intestinal problems
- ☐ Ulcers
- ☐ Special diet
- ☐ Unusual weight gain or loss
- ☐ Constipation/diarrhea
- ☐ Kidney or bladder problems
- ☐ Fainting spells, seizures or epilepsy
- ☐ Stroke(s)
- ☐ Frequent or severe headaches
- ☐ Thyroid problems
- ☐ Persistent cough or swollen glands
- ☐ Cancer/tumor
- ☐ Diabetes
- ☐ Thirsty or mouth is dry often
- ☐ Tuberculosis or other respiratory disease
- ☐ Bone or joint problems
- ☐ Arthritis
- ☐ Back or neck pain
- ☐ Joint replacement (e.g. hip, pins, implants)
- ☐ Drink alcohol? If so, how much? _____
- ☐ Use recreational drugs?
- ☐ History of alcohol or drug abuse?
- ☐ Hepatitis, jaundice or liver trouble
- ☐ Herpes or other STD
- ☐ HIV positive/AIDS
- ☐ Glaucoma
- ☐ Do you wear contact lenses?
- ☐ Head injury
- ☐ Epilepsy or other neurologic disease
- ☐ Other disease, condition or problem not listed above:_____

_____

WOMEN

- ☐ Are you pregnant? If so, expected delivery date:_____
- ☐ Are you nursing?
- ☐ Are you taking contraceptives or other hormones?
- ☐ Have you reached menopause? If so, any symptoms:_____

_____

Patient Signature / Legally Authorized Representative:	**Date:**
Print Name:	**Relationship:**
Doctor Signature:	**Date**