JAMES STREET
DENTAL ARTS

Patient Name: _____

Birth Date: _____ **Date:** _____

Are you under physician's care? Date of last exam? ☐ Yes ☐ No If Yes: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If Yes: _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If Yes: _____

_____

_____

Have you taken bisphosphonates {Ie. Fosamax, Boniva) ☐ Yes ☐ No If Yes: _____

Have you taken cortisone (steroids) medications? ☐ Yes ☐ No If Yes: _____

Have you been recommended to take antibiotic premedication for dental treatment? ☐ Yes ☐ No If Yes: _____

Do you smoke or use tobacco products? ☐ Yes ☐ No If Yes: _____

Have you used controlled substances? ☐ Yes ☐ No If Yes: _____

Do you have difficulty reclining fully in a dental chair? ☐ Yes ☐ No If Yes: _____

Do you have any impairments or limitations?

☐ Visual ☐ Hearing ☐ Physical ☐ Cognitive

Have you ever experienced any of these complications prior to dental treatment?

☐ Prolonged bleeding ☐ Anesthetic reaction ☐ Fainting ☐ Dental Anxiety

☐ Other _____

Are you allergic to the following:

☐ Latex ☐ Local Anesthetic ☐ Penicillin/Amoxicillin ☐ Codeine ☐ Other _____

☐ Acrylic ☐ Sulfa drugs ☐ Aspirin ☐ Metal _____

Women: Are you:

☐ Pregnant ☐ Nursing ☐ Taking oral contraceptives ☐ Trying to get pregnant

Do you have, or have you had, any of the following:

AIDS/HIV Positive ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Shingles ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No
Hepatitis B or C ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No	Sexually Trans. Disease ☐ Yes ☐ No	Cold Sores ☐ Yes ☐ No
Easily Winded ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Chest Pains ☐ Yes ☐ No	Bruise Easily ☐ Yes ☐ No
Excessive Bleeding ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No
Excessive Thirst ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No	Anaphylaxis ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No	Kidney/Bladder Dis. ☐ Yes ☐ No	Stomach/Intes. Dis. ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No	GERD ☐ Yes ☐ No
High Cholesterol ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Heart Trouble/Dis. ☐ Yes ☐ No
Heart Attack/Failure ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Cong. Heart Disorder ☐ Yes ☐ No	Heart Murmur/MVP ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Stent Placement ☐ Yes ☐ No	Artificial Heart Valve ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No
Stroke ☐ Yes ☐ No	Aneurism ☐ Yes ☐ No	Emphysema/COPD ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Blood Transfusion ☐ Yes ☐ No	Blood Disease ☐ Yes ☐ No	Anemia ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Chemo/Radiation ☐ Yes ☐ No	Organ Transplant ☐ Yes ☐ No	Artificial Joint ☐ Yes ☐ No
Osteoporosis ☐ Yes ☐ No	Rheumatoid Arthritis ☐ Yes ☐ No	Alzheimer/Dementia ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No
Psychiatric Care ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No	Gout ☐ Yes ☐ No		

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If Yes: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient, Parent or Guardian

X _____ Date _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Patient Information

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Soc. Sec.: _____

Email: _____ ☐ I would like to receive s=correspondences via email ☐ Text Messages

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc. Sec.: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.# or ID# _____ Insured Birth date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ State/City/Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.# or ID# _____ Insured Birth date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ State/City/Zip: _____

Dental History

Did someone refer you? ☐ Yes ☐ No If Yes:_____

Date of last dental visit? _____

What did you have done? _____

Please describe the reason for this visit: _____

What would best describe your past dental care: ☐ Routine ☐ Episodic ☐ Only when I have problems ☐ First visit

How would you describe your present oral condition?

☐ Good ☐ Fair ☐ Poor

Do you brush at least 2x per day? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Have you had radiation treatment to head or neck? ☐ Yes ☐ No

Those with dentures or partials, are they:

Comfortable? ☐ Yes ☐ No

Esthetically pleasing? ☐ Yes ☐ No

Over 10 years old? ☐ Yes ☐ No

Comment:_____

Do you currently experience any of the following:

☐ gag easily
☐ teeth sensitive to hot or cold
☐ teeth sensitive to sour
☐ dry mouth
☐ gums that bleed when brushing or flossing
☐ teeth sensitive to pressure
☐ floss that catches, frays or break
☐ trouble talking
☐ generally sensitive teeth
☐ teeth sensitive to sweets
☐ food that gets caught in teeth

☐ pain, soreness, or tenderness in any head or neck muscles
☐ awareness of noises in the jaw joint
☐ pain around the ears, temple, or cheeks
☐ previous jaw joint problem
☐ clenching or grinding
☐ pain when chewing or talking
☐ bite that feels uncomfortable or unusual
☐ pain or difficulty opening mouth
☐ jaws that get stuck
☐ frequent headaches

Patient, Parent, or Guardians Signature:_____ Date:_____