Northampton Family & Cosmetic Dentistry
www.EnjoyYourSmile.com

Date _____ Patient name _____ Name you wish to be called _____
Date of birth: ___/ ___/ _____ Age: _____ Sex: Male Female Other

Mailing address_____ City _____ State _____ Zip code _____
Home phone: _____Work phone: _____
Cell phone: _____ Email:_____
Preferred method of contact (phone/email): _____

Occupation:_____ Employer: _____
Employer address:_____ Employer phone:_____

Status: □Minor □Single □Married □Widowed □Separated □Divorced □Partner

How did you hear about us? _____

IN CASE OF AN EMERGENCY PLEASE CONTACT

Name _____ Relationship to you_____
Home phone_____ Work phone_____ Cell phone_____
Who is your medical doctor? _____
Medical doctor's phone _____Date of last exam _____

DENTAL HISTORY

Reason for today's visit _____
Are you in pain? _____ How long? _____ Where is the pain? _____
Do you require antibiotic pre-medication? _____ ***If yes, what medication****?* _____
Former dentist _____ City/ State _____
Phone # _____Date of last dental visit_____ Date of last dental x-rays_____

Please indicate if you have or had any of the following:

Bad breath	□Yes □No □Don't know	Clicking or popping jaw	□Yes □No □Don't know
Burning sensation in mouth	□Yes □No □Don't know	Piercing(s) in your mouth	□Yes □No □Don't know
Food trapping between teeth	□Yes □No □Don't know	Jaw pain or tiredness	□Yes □No □Don't know
Dry mouth	□Yes □No □Don't know	Mouth breathing	□Yes □No □Don't know
Gums swollen/tender/bleed	□Yes □No □Don't know	Gum disease/Gum treatment	□Yes □No □Don't know
Sores/growths in your mouth	□Yes □No □Don't know	Loose teeth	□Yes □No □Don't know
Sensitivity to hot/cold /sweets	□Yes □No □Don't know	Broken fillings/teeth	□Yes □No □Don't know
Root canals	□Yes □No □Don't know	Fingernail biting	□Yes □No □Don't know
Lip/cheek biting	□Yes □No □Don't know	Grinding teeth	□Yes □No □Don't know
Orthodontic treatment	□Yes □No □Don't know	Removable dental appliance	□Yes □No □Don't know
Any crowns/caps	□Yes □No □Don't know	Any teeth extracted	□Yes □No □Don't know
Bleached your teeth	□Yes □No □Don't know	Tooth ache	□Yes □No □Don't know
*If yes, when did you last touch-up?*_____		Citrus sucker	_____ Frequency
		Ice chewer	_____ Frequency
Carbonated beverages	_____ # ounces/day	Hard candy/cough drop sucker	_____ Frequency

Would you like nitrous oxide/laughing gas for dental treatments in our office? □Yes □No □Don't know
How often do you brush? _____ How often do you floss? _____
What type of tooth bristles do you use (soft/hard/med/electric/etc)? _____

MEDICAL HISTORY

Please indicate if you have or had any of the following:

Acid reflux	□Yes □No □Don't know	HIV positive	□Yes □No □Don't know
Anemia	□Yes □No □Don't know	Kidney disease	□Yes □No □Don't know
Angina	□Yes □No □Don't know	Liver disease	□Yes □No □Don't know
Arthritis/rheumatism	□Yes □No □Don't know	Low blood pressure	□Yes □No □Don't know
Artificial heart valves	□Yes □No □Don't know	Nervous problems	□Yes □No □Don't know
Artificial Joints	□Yes □No □Don't know	Pacemaker	□Yes □No □Don't know
Asthma	□Yes □No □Don't know	Psychiatric care	□Yes □No □Don't know
Back problems	□Yes □No □Don't know	Recurrent infections	□Yes □No □Don't know
Bleeding abnormally	□Yes □No □Don't know	Rheumatic fever	□Yes □No □Don't know
Cancer	□Yes □No □Don't know	Shortness of breath	□Yes □No □Don't know
Chemo/radiation	□Yes □No □Don't know	Sinus trouble	□Yes □No □Don't know
Cigarette/tobacco use	□Yes How much? □No	Special diet	□Yes □No □Don't know
Congenital heart lesions	□Yes □No □Don't know	Steroid treatments	□Yes □No □Don't know
Contact lenses	□Yes □No □Don't know	Stomach problems	□Yes □No □Don't know
Cough persistent/bloody	□Yes □No □Don't know	Stroke	□Yes □No □Don't know
Diabetes/Type I or II	□Yes □No □Don't know	Swelling of feet/ankles	□Yes □No □Don't know
Drinking alcohol	□Yes How much? □No	Swollen glands	□Yes □No □Don't know
Drug dependency	□Yes □No □Don't know	Thyroid problems	□Yes □No □Don't know
Recreational drug use	□Yes What kind? □No	Tuberculosis	□Yes □No □Don't know
Eating disorder	□Yes □No □Don't know	Tumors	□Yes □No □Don't know
Emphysema	□Yes □No □Don't know	Ulcer/s	□Yes □No □Don't know
Epilepsy	□Yes □No □Don't know	Venereal disease	□Yes □No □Don't know
Fainting/dizziness	□Yes □No □Don't know	Weight loss *(unexplained)*	□Yes □No □Don't know
Glaucoma	□Yes □No □Don't know	Other diseases	□Yes □No □Don't know
Headaches/migraines	□Yes □No □Don't know		
Heart problems	□Yes □No □Don't know	Any bone density medications or bisphosphonates (Aredia, Zometa, etc.)	□Yes □No □Don't know
Hepatitis/ Type	□Yes □No □Don't know		
High blood pressure	□Yes □No □Don't know		
Have you ever been involved in medical or dental legal activity?	□Yes □No □Don't know	*__Women Only:__ Are you pregnant?	□Yes □No □Don't know
Have you been hospitalized in the past 5yrs?	□Yes □No	If yes, due date:	
		Are you nursing?	□Yes □No

Notes/Comments:

MEDICATIONS, HERBAL SUPPLEMENTS

Please list everything you are currently taking:

_____

_____

_____

_____

Pharmacy name _____

Phone _____

ALLERGIES

□Aspirin □Local anesthetic
□Codeine □Penicillin
□Iodine □Sulfa
□Latex □Metals
□Barbiturates (sleeping pills)
□Other _____

_____

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs.

I certify I have read and understand the above and have had an opportunity to ask questions.

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Doctor's Signature **Date**