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? _____

If applicable, with whom do you want us to discuss your care/appointment status, etc.? (please provide the name of the individual(s) and their relationship to you (parent, spouse, etc.)) _____

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
Anemia	☐Yes	☐No	☐Don't know
Angina	☐Yes	☐No	☐Don't know
Arthritis/rheumatism	☐Yes	☐No	☐Don't know
Artificial heart valves	☐Yes	☐No	☐Don't know
Artificial Joints	☐Yes	☐No	☐Don't know
Asthma	☐Yes	☐No	☐Don't know
Back problems	☐Yes	☐No	☐Don't know
Bleeding abnormally	☐Yes	☐No	☐Don't know
Cancer	☐Yes	☐No	☐Don't know
Chemo/radiation	☐Yes	☐No	☐Don't know
Cigarette/tobacco use	☐Yes	How much?	☐No
Congenital heart lesions	☐Yes	☐No	☐Don't know
Contact lenses	☐Yes	☐No	☐Don't know
Cough persistent/bloody	☐Yes	☐No	☐Don't know
Diabetes/Type I or II	☐Yes	☐No	☐Don't know
Drinking alcohol	☐Yes	How much?	☐No
Drug dependency	☐Yes	☐No	☐Don't know
Recreational drug use	☐Yes	What kind?	☐No
Eating disorder	☐Yes	☐No	☐Don't know
Emphysema	☐Yes	☐No	☐Don't know
Epilepsy	☐Yes	☐No	☐Don't know
Fainting/dizziness	☐Yes	☐No	☐Don't know
Glaucoma	☐Yes	☐No	☐Don't know
Headaches/migraines	☐Yes	☐No	☐Don't know
Heart problems	☐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
Have you been hospitalized in the past 5yrs?	☐Yes	☐No	

HIV positive	☐Yes	☐No	☐Don't know
Kidney disease	☐Yes	☐No	☐Don't know
Liver disease	☐Yes	☐No	☐Don't know
Low blood pressure	☐Yes	☐No	☐Don't know
Nervous problems	☐Yes	☐No	☐Don't know
Pacemaker	☐Yes	☐No	☐Don't know
Psychiatric care	☐Yes	☐No	☐Don't know
Recurrent infections	☐Yes	☐No	☐Don't know
Rheumatic fever	☐Yes	☐No	☐Don't know
Shortness of breath	☐Yes	☐No	☐Don't know
Sinus trouble	☐Yes	☐No	☐Don't know
Special diet	☐Yes	☐No	☐Don't know
Steroid treatments	☐Yes	☐No	☐Don't know
Stomach problems	☐Yes	☐No	☐Don't know
Stroke	☐Yes	☐No	☐Don't know
Swelling of feet/ankles	☐Yes	☐No	☐Don't know
Swollen glands	☐Yes	☐No	☐Don't know
Thyroid problems	☐Yes	☐No	☐Don't know
Tuberculosis	☐Yes	☐No	☐Don't know
Tumors	☐Yes	☐No	☐Don't know
Ulcer/s	☐Yes	☐No	☐Don't know
Venereal disease	☐Yes	☐No	☐Don't know
Weight loss *(unexplained)*	☐Yes	☐No	☐Don't know
Other diseases	☐Yes	☐No	☐Don't know

Any bone density medications or bisphosphonates (Aredia, Zometa, etc.) ☐Yes ☐No ☐Don't know

***Women Only:**

Are you pregnant? ☐Yes ☐No ☐Don't know

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**