PQ Family Dental

Date: _____

Tim Belnap, DDS | W. Brandon Jergensen, DDS

DENTAL REGISTRATION AND HISTORY

The benefits of a healthy, beautiful smile are immeasurable. Our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. The information on this form is confidential and will enable us to provide you with the best care possible.

PATIENT INFORMATION

Dr. Mr. Mrs. Ms. Miss

Patient Name: _____
Last First MI.

I prefer to be called: _____

Sex: M F Age: _____

Married Widow(er) Single Minor Separated Divorced

Birthdate: _____

How did you hear about our practice? _____

Whom may we thank for referring you? _____

DENTAL HISTORY

Reason for today's visit: _____

Date of last dental visit: _____

Date of last bitewing x-rays or checkup x-rays: _____

Date of last Panorex or full mouth series: _____

Do we have your permission to request your x-rays: _____

If yes, was the treatment completed? _____

Have you ever been told that you need to take an antibiotic or have you ever taken an antibiotic prior to any dental treatment? _____

Are you currently experiencing any tooth pain? _____

Former Dentist: _____

City/State/Phone: _____

HEALTH HISTORY

How do you assess your current health?

Excellent Good Fair Poor

Any change to your health in the last year? Y N

Primary physician's name and phone number:

_____

Date of last physical exam: _____

Are you currently under the care of a physician? Y N

Have you been hospitalized or had any serious medical problem within the last 5 years? Y N

If so, please describe: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include the combinations of Ionimine, Adipex, Fastin (brand names or Phentermine), Pondimin (Fenfluramine) and Redux (Dexfenfluramin)? Y N

Have you ever or are you currently taking any of the group of drugs for Osteoporosis (Bisphosphonates)? Y N

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

___ Bad Breath
___ Bite lips/cheeks regularly
___ Biting or chewing sensitivity
___ Bleeding gums
___ Burning on tongue
___ Change in your bite
___ Cigarette, pipe, chewing tobacco or cigar smoking
___ Clicking or popping jaw
___ Dental implant -- Date _____
___ Difficulty in opening/closing
___ Dry mouth
___ Fingernail biting
___ Food caught between teeth
___ Grinding and/or clenching teeth
___ Gums swollen or tender
___ Headaches or neck pain
___ Jaw pain, especially in the morning
___ Loose teeth or broken fillings
___ Mouth breathing, asleep or awake
___ Mouth or night guard
___ Mouth pain when brushing
___ Nervous about having dental treatment
___ Orthodontic treatment
___ Pain around ear
___ Parents/family with gum disease or tooth loss
___ Root canals
___ Sensitivity to cold/hot
___ Sensitivity to sweets/sour
___ Sores or growths in mouth
___ Wisdom teeth removed

How often do you floss? _____ per day

How often do you brush? _____ per day

Have you ever been told that you have/had periodontal disease? Y N

Have you had problems with prior dental treatments? Y N

Have you ever whitened your teeth? Y N

Are you happy with your smile? Y N

If you had a magic wand, what would you change about your smile? _____

Please check all of the following that pertain to you:

___ Acid Reflux disease
___ Angina
___ Artificial heart valves/stints
___ Artificial joints
___ Arthritis
___ Asthma
___ Back problems
___ Bleeding abnormally, with extractions/surgery
___ Blood disease
___ Chemotherapy
___ Chest pains
___ Chough, persistent or bloody
___ Cold sores
___ Congenital heart lesions
___ Depression
___ Diabetes – Type _____
___ Drug/chemical dependency
___ Emphysema
___ Epilepsy or seizures
___ Fainting or dizziness
___ GERD
___ Gout
___ Heart attack
___ Heart murmur
___ Heart problems
___ Hepatitis -- Type ___ Treatment _____
___ Herpes
___ High Cholesterol
___ High or low blood pressure
___ HIV/AIDS
___ Joint replacement
___ Kidney disease
___ Leukemia
___ Liver disease
___ Migraines
___ Mitral Valve Prolapse
___ Nervous problems
___ Osteoporosis
___ Pacemaker
___ Psychiatric treatment
___ Radiation therapy
___ Respiratory disease
___ Rheumatic Fever
___ Scarlet Fever
___ Shortness of breath
___ Sinus trouble
___ Stroke
___ Swollen neck glands
___ Thyroid disease
___ Tonsillitis
___ Tuberculosis
___ Tumor or growth
___ Venereal disease

WOMEN:

___ Nursing
___ Birth control pills
___ Pregnant Due date: _____
___ Could be pregnant

___ None of the above

MEDICATIONS

List medication(s) you are currently taking, including non-prescription or over-the-counter and dosages.

_____

_____

_____

ALLERGIES

___ Aspirin
___ Barbiturates (sleeping pills)
___ Codeine
___ Iodine
___ Latex
___ Food _____
___ Other _____
___ Local Anesthetic
___ Metal
___ Penicillin
___ Sedatives
___ Sulfa drugs

UPDATES: (Office use)

Date: _____
What condition: _____
New medications: _____
Provider signature: _____
Patient signature: _____

Date: _____
What condition: _____
New medications: _____
Provider signature: _____
Patient signature: _____

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What condition: _____
New medications: _____
Provider signature: _____
Patient signature: _____

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