ROSE DENTAL GROUP

PATIENT HEALTH and DENTAL INFORMATION

Date _____________

PATIENT INFORMATION

NAME ___________________________________
Address ___________________________________
City/State/Zip ______________________________
Hm. Phone _________________________________
Employer __________________________________
Other Phone ________________________________
Email Address ______________________________
Sex (Circle One) M F Drivers Lic. # ____________
Social Security #__________________DOB_______
Marital Status (Circle One) S M

POLICY HOLDER INFORMATION

NAME ____
Address____
City/State/Zip ______________________________________
Phone # ____
Employer ____
Social Security # _______________DOB_______________
Dental Insurance _________________Group # ___________

MEDICAL HISTORY

Do you have any of the following:

Yes No
___ ___ Abnormal blood pressure
___ ___ Anemia
___ ___ Arthritis
___ ___ Artificial Valve
___ ___ Blood transfusion
___ ___ Circulatory problems
___ ___ Diabetes
___ ___ Diagnosis of ARC/HIV
___ ___ Epilepsy
___ ___ Excessive bleeding

Yes No
___ ___ Fainting tendency
___ ___ Glaucoma
___ ___ Heart problems (Heart Murmur)
___ ___ Hepatitis A (infectious)
___ ___ Hepatitis B (serum)
___ ___ Jaundice
___ ___ Joint Replacement
___ ___ Malignancies
___ ___ Nursing mother currently?
___ ___ Pregnant currently?
Due Date ____________

Yes No
___ ___ Respiratory problems (Asthma, emphysema, etc.)
___ ___ Rheumatic fever
___ ___ Sinus Problems
___ ___ Stroke
___ ___Tested positive for AIDS/HIV
___ ___ Thyroid disease
___ ___ Tuberculosis
___ ___ Unfavorable reaction to dental anesthetic
___ ___ Venereal disease

Other ____
____

Do you have a condition that requires antibiotic premedication before dental appointments (Y or N)?
Do you use any tobacco products? (Y or N) If YES, what type? ____
Are you allergic to any medications? (Y or N) If YES, please list ____
Are you currently taking any medication? (Y or N) If YES, please list _______________________________________
Are there any other medical conditions of which we should be made aware? __________________________________
Physician's Name & Phone # _______________________________ Date of Last Physical Exam ___________________
Preferred Pharmacy & Phone # ____
Are you presently under the care of a physician? (Y or N) If YES, for what? __________________________________
Have you ever been hospitalized? (Y or N) If YES, for what? ____

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DENTAL HISTORY

Are you currently experiencing a toothache or any other pain in your head or neck? If so, please describe: ________________
____

Date of your last dental treatment or cleaning? _____________Date of last dental X-Rays __________What type?__________

Do you have a history of:

YES	NO		YES	NO		YES	NO	
___	___	Gum Disease	___	___	Halitosis (Bad Breath)	___	___	Grinding Teeth (BRUXISM)
___	___	Abscesses	___	___	Teeth Sensitivities	___	___	Clicking or Popping TMJ
___	___	Sores (Ulcers)	___	___	Cold Sores/Fever Blisters	___	___	Pain in Jaw Joint

Are there any other dental conditions or experiences of which we should be made aware? ______________________________

SMILE EVALUATION

1. Do you like the way your teeth look? Yes ☐ No ☐
   If no explain:____
2. Are you happy with the color of your teeth? Yes ☐ No ☐
   If no, please explain:____
3. Would you like your teeth to be whiter? Yes ☐ No ☐
4. Would you like your teeth to be straighter? Yes ☐ No ☐
   If yes, please explain:____
5. Do you have spaces between your teeth that you would like closed? Yes ☐ No ☐
6. Would you like your teeth to be longer? Yes ☐ No ☐
   If yes, where:____
7. Do you like the shape of your teeth? Yes ☐ No ☐
   If no, please explain:____
8. Do you have missing teeth that you would like to replace? Yes ☐ No ☐
9. Do you have old silver fillings that you would like to replace with tooth colored fillings? Yes ☐ No ☐
10. If you could change anything about your smile, what would you change?
    ____

Person to contact outside of immediate family in case of emergency Name __________________________Phone # _________________ Alternative #_____________

REFERRAL SOURCE

Family Member _____ Yellow Pages _____ Sign _____ Mail _____ Other-Specify ____________________

Thank you for choosing us. All information you give us is strictly confidential and will not be released to anyone without written consent.

_________________________________ Signature (Patient, Parent, or Guardian)

____________________________ Doctor's Signature

______________ Date

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