

# DENTAL ARTS OF FREDERICK, L.L.C.

Date: \_\_\_\_\_

**Patients Name:** \_\_\_\_\_  
 Male:  Female:   
 Date of Birth: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Work Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_

**Parent/Spouses Name:** \_\_\_\_\_  
 Parent/Spouses Date Of Birth: \_\_\_\_\_  
 Parent/Spouses Social Security #: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Who referred you to our office? \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_

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I understand that the information provided by me on this form is essential to determine my dental needs and the provision of dental treatment. I understand that if any change occurs in my health, I am to report that change to the dental office as soon as possible.

	YES	NO		YES	NO
Are your teeth sensitive to:					
heat	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any general health problems	<input type="checkbox"/>	<input type="checkbox"/>
cold	<input type="checkbox"/>	<input type="checkbox"/>	If so, please specify: _____		
sweets	<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
biting pressure	<input type="checkbox"/>	<input type="checkbox"/>	If so, please specify: _____		
Does food catch between your teeth	<input type="checkbox"/>	<input type="checkbox"/>	Are you under a physicians care?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when brushing	<input type="checkbox"/>	<input type="checkbox"/>	Please list any medications you are taking:		
Any gum swelling around any teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Any unpleasant taste/odor in your mouth	<input type="checkbox"/>	<input type="checkbox"/>	To the best of your knowledge, are you or have you		
Do you avoid parts of the mouth while brushing	<input type="checkbox"/>	<input type="checkbox"/>	Ever been afflicted with:		
Do you notice any clicking of the jaw	<input type="checkbox"/>	<input type="checkbox"/>	Heart Ailment _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in jaw joints	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
ears or side of the face	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty opening/closing the jaw	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty chewing	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any teeth removed	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis _____	<input type="checkbox"/>	<input type="checkbox"/>
How long have these teeth been missing _____			HIV Positive _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a reaction to local anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>
anesthetic name: _____			Allergies to Any Drugs? _____		
What is your present dental problem? _____			Allergies to Any Metals? _____		
When was your last dental visit? _____			Allergies to Latex? _____	<input type="checkbox"/>	<input type="checkbox"/>
			Are you Pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you dissatisfied with your teeth/their appearance	<input type="checkbox"/>	<input type="checkbox"/>	Is there anything else that we should know about		
			your current or past health history? _____		

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Witness: \_\_\_\_\_ Date: \_\_\_\_\_  
 Dentist Reviewing with Patient: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_