www.OverlandParkDentist.com

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We would like to get to know you better!

About You

Today's Date: _____
Name: _____
Last First Middle
I prefer to be called: _____
Birthdate: _____
SS #: _____
Marital Status: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____
Home Address: _____
_____
_____
_____
City State Zip Code
Occupation: _____
Employer: _____
Employer Address: _____
_____
_____
_____
City State Zip Code

Who may we THANK for referring you? _____
_____

Spouse Information

Name: _____
Occupation: _____
Employer: _____
Work Phone: _____

Dental Insurance

Insurance Co. Name: _____
Address: _____
_____
_____
_____
City State Zip Code
Insurance Co Ph #: _____
Group # (Plan, Local or Policy #): _____
Insured's Name: _____
Insured's Birthday: _____
Insured's SS#: _____
Insured's Employers: _____

Health History

→ If you have a personal physician
Their Name: _____
Their Phone: _____

→ Are you taking any prescriptions/over the counter drugs? ☐ Yes ☐ No
If yes, List: _____
_____

→ Do you need to be premedicated for artificial joints, heart murmer or mitral valve prolapsed before dental treatment?
☐ Yes ☐ No

→ Have you had any serious medical problems in the last 5 years? ☐ Yes ☐ No
If yes, please explain: _____
_____

→ For women: Are you pregnant
☐ Yes ☐ No

→ To the best of your knowledge, are you or have you ever been afflicted with:

☐ Heart Attack/Stroke
☐ Rheumatic Fever
☐ Shingles
☐ Chronic Hepatitis
☐ Cancer/Chemotherapy
☐ Psychiatric Problems
☐ Severe Headaches
☐ Anemia
☐ Drug/Alcohol Abuse
☐ Hemophilia/Abnormal Bleeding
☐ Low Blood Pressure
☐ High Blood Pressure
☐ Heart Surgery/Pacemaker
☐ Epilepsy/Seizures/Fainting
☐ Heart Murmer
☐ HIV+, AIDS
☐ Kidney Problems
☐ Sinus Problems
☐ Fever Blisters
☐ Tuberculosis (TB)
☐ Diabetes
☐ Sickle Cell Disease

→ Are you allergic to any of the following drugs?

☐ Penicillin
☐ Erythromycin
☐ Dental Anesthetics
☐ Sulfur
☐ Other
☐ Tetracycline
☐ Codeine
☐ Latex
☐ Aspirin

Continue → → →

Dental History

→ Do You like your smile? Yes No
If no, what would you like to change about your smile? (Size, color, shape, spaces, Etc.)
_____

→ Do you get frustrated because you always have something to be treated or repaired when you visit a dentist Yes No

→ Are your teeth sensitive to:
☐ Heat ☐ Cold ☐ Sweets ☐ Biting Pressure

→ If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead? Yes No

→ Have you ever had any teeth removed? Yes No
If yes, how long ago? _____

→ How many time(s) a day do you brush your teeth? _____

→ How many time(s) a week do you floss? _____

→ Do your gums bleed when brushing or flossing? Yes No

→ Do you smoke or use tobacco in any other form? Yes No
If yes, how much _____

→ Do you want to learn to control dental disease and retain your teeth? Yes No

→ Has the fear of discomfort kept you from regular dental visits? Yes No

→ Do you have frequent headaches Yes No

→ Do you have TMJ Discomfort? Yes No
Clicking / popping / jaw pain / headaches / clenching / grinding

→ Do you know if you grind your teeth? Yes No

→ I give Dr. Patel permission to use any pictures he takes of me or my teeth Yes No

→ What prompted you to seek dental care at this time? _____
_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature Date