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www.OverlandParkDentist.com

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

→ Are you allergic to any of the following drugs?

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

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