Broadway Family Dentistry

PATIENT'S HISTORY AND INFORMATION

(Mr. Mrs. Ms. Dr.)
Name ______ Nickname ______ Date of Birth ______ Age ____
Address Street ______ City ______ Zip ______
Soc. Security Number ______ Referred By ______
Telephone (Home) ______ (Cell) ______ (Email) ______
Employed by ______ Occupation ______ Phone ______
Emergency Contact ______ Phone ______
Person financially responsible ______ Address ______ Phone ______
Dental Insurance Information:

Primary ______	Secondary ______
Subscriber ______	Subscriber ______
Birthdate ______	Birthdate ______
Soc. Sec. No. ______	Soc. Sec. No. ______
Employers ______	Employer ______
Group No. ______	Group No. ______

MEDICAL HISTORY

Family Physician ______ Office Phone ______ Last Exam ______
Are you under any medical treatment now? ______
Have you had any major operations? If so, what? ______
Have you ever had a serious accident involving head injuries? ______
Have you ever had a blood transfusion? ______
Has a physician ever informed you that you had:

	Yes	No		Yes	No		Yes	No
Heart Ailment	____	____	AIDS, HIV	____	____	Any Intestinal Disease	____	____
Pacemaker	____	____	Artificial Joint	____	____	Any Venereal Disease	____	____
Artificial Heart Valve	____	____	Rheumatism or Arthritis	____	____	Yellow Jaundice or Hepatitis	____	____
High Blood Pressure	____	____	Tumor, Growths or Cancer	____	____	Diabetes	____	____
Heart Murmur	____	____	Any Blood Disease	____	____	Asthma	____	____
Rheumatic Fever	____	____	Any Liver Disease	____	____	Bleeding Disorder	____	____
Thyroid Disease	____	____	Any Kidney Disease	____	____	Nervous Disorder	____	____
Respiratory Disease	____	____	Any Stomach Disease	____	____			

What drugs or medication are you taking? ______
Are you in general good health at this time? ______
Have any wounds healed slowly or presented other complications? ______
Do you have a history of fainting? ______
Have you ever had any RADIATION TREATMENTS? ______
Women: Are you pregnant? ______ If yes, due date ______

ALLERGIES

Are you allergic to or have you had a reaction to: (to all **YES** responses, specify type of reaction - check DK if you do not know the answer):

	Yes	No	DK		Yes	No	DK
Local anesthetics ______	___	___	___	Latex (rubber) ______	___	___	___
Aspirin ______	___	___	___	Iodine ______	___	___	___
Penicillin or other antibiotics ______	___	___	___	Hayfever / seasonal ______	___	___	___
Barbiturates, sedatives, or sleeping pills ______	___	___	___	Animals ______	___	___	___
Sulfa drugs ______	___	___	___	Food ______	___	___	___
Codeine or other narcotics ______	___	___	___	Other ______	___	___	___
Metals ______	___	___	___				

Please complete other side →

DENTAL HISTORY

Date of last dental visit________________________ Date of last full mouth x-rays________________________

Have you had previous bad dental experience?___ if yes please explain:________________________

Have you ever had any of the following:

MOUTH	Yes	No
Bleeding, sore gums	____	____
Unpleasant taste/bad breath	____	____
Burning tongue/lips	____	____
Frequent blister, lip/mouth	____	____
Swelling, lumps in mouth	____	____
Ortho treatments (braces)	____	____
Clicking, popping jaw/ difficult opening/closing	____	____

TEETH	Yes	No
Loose teeth	____	____
Sensitive to hot/cold sweets	____	____
Sensitive to biting/change in bite	____	____
Clenching/grinding	____	____

Reason for today's visit ________________________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or medication, I will inform the dentist at the next appointment.

Signature of Patient, Parent or Guardian________________________ Date ________

Signature of Doctor________________________Date ________

Have there been any changes in your health since your last dental visit?

Date ________ Doctor's Signature ________________ Patient Signature________________

Date ________ Doctor's Signature ________________ Patient Signature________________

Date ________ Doctor's Signature ________________ Patient Signature________________

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