Welcome to Georgetown Dental – Tell Us About Yourself

Name: _____ DOB:_____

First Middle Last Title

Preferred name: _____ SS#_____ □ **Male** □ **Female**

Email: _____ Occupation: _____

Address: _____ City: _____ State _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Alt. phone: _____

Driver License #: _____ Marital Status: □ **Single** □ **Married** □ **Minor** □**Divorced** □ **Widowed**

Spouse/Guardian's name: _____How did you hear about our office? _____

Emergency contact: Name: _____ Number: _____ Relationship: _____

Dental Insurance – Primary

Subscriber's Information:

Name: _____ Relationship to patient: _____ DOB _____

Employer: _____ SS#/ID:_____ Driver License #: _____

Insurance Information:

Name:_____ Address:_____

Phone Number: _____ Group Number: _____ ID#:_____

Please tell us what brings you in today:

_____

_____

Please rate your overall health? ☐**Excellent** ☐**Very Good** ☐**Good** ☐**Fair** ☐**Poor**

Height: _____ Weight: _____

Pharmacy information (Name/Location/ Phone#): _____

Physician's Name and number: _____

Previous Dentist:_____ _____

Have you ever been told to take antibiotics prior to Dental treatment or surgical care? □ Yes □No

If yes, please tell us why _____

List any prescription or OTC medications/ supplements you're taking

Medication	Reason	Dose/frequency

List all surgeries, hospitalizations, &blood transfusions

Year	Description

Please let us know of any allergies / reactions:

□ Penicillin/Amoxicillin:n_____ □ Aspirin: _____

□ Clindamycin:_____ □ Metals (Nickel, Mercury, etc);_____

□ Latex: _____ □ Barbiturates/ Sedatives:_____

□ Sulfa drugs:_____ □ Codeine / other narcotics:_____

□ Iodine:_____ □ Other : _____

Are you currently or have you ever taken any **bisphosphonate or bisphosphonate-like medication** for osteoporosis, osteopenia, hyperkalemia, Paget's disease, cancer or multiple Myeloma? Ex: Alendronate (Fosamax), Risedronate (Actonel), Prolia, Aredia, Zometa etc.□ **No** □ **Yes**

If yes: Medication: _____ □IV □ORALLY

Start date: _____ Finish date_____

How many Alcoholic drinks do you have in a typical week? ___

Do you use tobacco? □ Yes □No type :_____

If cigarettes, how many packs per day? _____ Years? _____

If yes, how interested are you in quitting?

□**Very** □**Somewhat** □ **Not Interested**

Please Indicate/describe any medical conditions you currently have or had in the past.

□ High Blood Pressure_____

□ Low Blood Pressure_____

□ Angina _____

□ Congenital Heart Defect_____

□ Mitral Valve Prolapse_____

□ Pace Maker_____

□ Heart Attack_____

□ Heart Disease_____

□ High Cholesterol_____

□ Heart Surgery_____

□ Hemophilia_____

□ Abnormal bleeding _____

□ Anemia_____

□Artificial Heart Valve _____

□Rheumatic Fever_____

□ Seasonal Allergies _____

□ Asthma _____

□ Emphysema _____

□ Difficulty Breathing_____

□ Fainting Spells_____

□ Sinus Problems_____

□ Arthritis _____

□ Chronic Pain_____

□ Osteoporosis_____

□ Osteopenia_____

□ Joint Replacement_____

□ Frequent Headaches_____

□ Neuropathy_____

□ Fibromyalgia_____

□ Cancer _____

□ Radiation Therapy _____

□ Chemotherapy _____

□ Leukemia/Lymphoma _____

□ Diabetes- Type : I or II_____

□ Kidney problems_____

□ HIV/AIDS_____

□ Hepatitis A _____

□ Hepatitis B _____

□ Hepatitis C_____

□ Sexually Transmitted Disease_____

□ Lupus Erythematous_____

□ Liver Disease_____

□ Multiple Sclerosis _____

□ Tuberculosis_____

□ Recurrent Infection_____

□ Neurological Disorder _____

□ Genetic/ Hereditary Disease _____

□ Glaucoma _____

□ Drug Abuse_____

□ Alcohol Abuse_____

□ Psychiatric Problems_____

□ Epilepsy_____

□ Depression _____

□ Chronic Fatigue syndrome _____

□ Seizures_____

□ Shingles_____

□ Sickle Cell Disease_____

□ Stroke_____

□ Thyroid Problems _____

□ Ulcers_____

□ Ulcerative Colitis_____

□ Irritable Bowel Syndrome (IBS) _____

□ Reflux_____

□ Fever Blisters/ cold sores_____

□ Eating Disorder_____

□ Malnutrition_____

□ Temporomandibular Joint Disease _____

□ Facial Surgery _____

□ Pregnant _____

□ Nursing _____

□ Other Condition not listed _____

_____

Notes:

Please select any that you have or had in the past

□ Cleanings	□ Crowns	□ Fillings
□ Dentures	□ Partials	□ Bridge
□ Implants	□ Extractions	□ Root Canals
□ Periodontal treatment / deep cleanings		□ Gum surgery
□ Orthodontics	□ Retainers	□ CPAP
□ Night guard	□ Toothbrush abrasion	□ Sleep Apnea
□ Mandibular Advancement device		□ Jaw Surgery
□ Whitening	□ Nitrous Oxide	

Smile assessment

I am concerned about the appearance of my teeth?	□Yes □ No
I am concerned about the lack of whiteness of my teeth	□Yes □ No
I am concerned with the position/angle of one or more of my teeth	□Yes □ No
I am concerned about the shape of one or more of my teeth	□Yes □ No
In social situations, sometimes I'm embarrassed by my teeth or smile	□Yes □ No
There are things about my top front teeth I would like to change	□Yes □ No
I have old silver fillings I would like to make tooth colored	□Yes □ No
I have previous dental treatment that is no longer satisfactory to me	□Yes □ No
I am missing one or more of my teeth	□Yes □ No
I am interested in learning more about cosmetic dentistry	□Yes □ No
I am interested in learning more about replacing my missing teeth	□Yes □ No

Dental Information: Check if you currently or have had in the past

Bleeding when Brushing	□Yes □ No	Do you still have you still have your wisdom teeth	□Yes □ No
Bleeding when Flossing	□Yes □ No	Do you have Dental anxiety / fear?	□Yes □ No
Sensitivity to hot, cold, sweet or pressure	□Yes □ No	Do you prefer Nitrous oxide (laughing gas) for dental treatment?	□Yes □ No
Dry mouth	□Yes □ No	Do you prefer sedation for dental treatment?	□Yes □ No
Problems associated with past dental treatment	□Yes □ No	Have you ever had a sleep study?	□Yes □ No
Fluoridated home water supply	□Yes □ No	Have you ever had any complications with surgeries	□Yes □ No
Any clicking, popping, or discomfort in the jaw	□Yes □ No	Have you ever had any complications with sedation	□Yes □ No
Difficulty opening, closing or chewing	□Yes □ No	Would you like to know more about Invisalign	□Yes □ No
Clinching or grinding your teeth	□Yes □ No	Have you had your tonsils removed?	□Yes □ No
Ear aches or neck pains	□Yes □ No	Do you snore?	□Yes □ No
Ulcers or sores in your mouth	□Yes □ No		
Any serious injury to head, neck, mouth	□Yes □ No		
Bite your lips or cheeks frequently	□Yes □ No		

For children only (filled out by parent or guardian) – Sleep/ Airway/Dental questions

Are you aware of your child:

Snoring/ noisily breathing while sleeping	□Yes □ No	Do you assist with your child brushing	□Yes □ No
Grinding his or her teeth	□Yes □ No	Do you assist with your child flossing	□Yes □ No
Having frequent nightmares/night terrors	□Yes □ No	How many sugary drinks/ snacks does your child have per day	
Having difficulty in school/ learning	□Yes □ No	How many times a day does your child brush? _____	
Being treated for ADD or ADHD	□Yes □ No	Has your child ever had a bad dental experience?	□Yes □ No
Breathing primarily through their mouth	□Yes □ No	Does your child complain of mouth pain	□Yes □ No
Wetting the bed	□Yes □ No	Does your child take a bottle to bed	□Yes □ No
Having frequent ear aches	□Yes □ No		□Yes □ No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payors and/or health providers. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN IF MINOR) DATE

_____

DDS SIGNATURE DATE