COAL CREEK DENTISTRY

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Patient Information

Welcome. Thank you for providing the information below. If there have been changes since your last visit, please tell us. If you have a question, please don't hesitate to ask.

Name____Birth date____________Age_______Sex____
Home address________________________________City________________ST________Zip____
Billing address______________________________City________________ST________Zip____
Home phone________________Cell______________Email____________________________
Driver's license #______________State______________Social Security No.____________________
Spouse's name____Phone____________________
Emergency name (if not spouse)______________________________Phone____________________
Physician______________________________________Date of last visit____________________
Last dentist_____________________________________Date of last visit____________________
Who referred you?____

Insurance

Primary dental insurance__________________________________Group #________________
Secondary dental insurance________________________________Group #________________
Subscriber's name______________________________Birth date____________SS#____________

Dental Health & History

	Yes	No
Are you apprehensive about treatment?	☐	☐
Have you had problems with prior treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Do you have slow-healing mouth sores?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when you eat…		
Hot food or liquid?	☐	☐
Cold food or liquid?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

	Yes	No
How often do you brush?____________________		
How often do you floss?____________________		
Does your jaw make noise that bothers you?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Are you unable to freely open your jaw?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does it hurt when you chew or open wide?	☐	☐
Do you have earaches or pain in front of ears?	☐	☐
Do you have headaches when you wake up?	☐	☐
Does jaw pain impact your life?	☐	☐
Is jaw pain frustrating or depressing?	☐	☐
Do you take pain relievers?	☐	☐
Do you take muscle relaxants?	☐	☐
Do you take antidepressants?	☐	☐
Do you have TMJ?	☐	☐
Do your cheeks, joints, throat or face hurt?	☐	☐
Can you open your mouth as far as you want?	☐	☐
Is your bite uncomfortable?	☐	☐
Have you had trauma from a blow to the jaw?	☐	☐
Do you regularly chew gum or smoke a pipe?	☐	☐

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Medical Health History

	Yes	No
Heart Problems		
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems		
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems		
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems		
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems		
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., hip, pins, implant)	☐	☐
Fainting Spells, Seizures or Epilepsy	☐	☐
Stroke(s)	☐	☐
Frequent or Severe Headache	☐	☐
Thyroid Problems	☐	☐
Persistent Cough or Swollen Glands	☐	☐
Premedications Required by Your Physician	☐	☐
Cancer/Tumor	☐	☐
Are you allergic or have you reacted adversely to any of the following?		
Local anesthetics (e.g., Novocain)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other	☐	☐

	Yes	No
Diabetes	☐	☐
Urinate more than 6 times/day	☐	☐
Thirsty or dry mouth often	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much?____________________		
Do you smoke?	☐	☐
If so, how much?____________________		
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐
Any disease, condition or problem not listed?	☐	☐
In the past year, have you taken any…		
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase or similar	☐	☐
Aspirin	☐	☐
Digitalis or other drug for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drugs/supplements	☐	☐
Other	☐	☐
Women		
Taking contraceptives?	☐	☐
Taking other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, delivery date?__________________		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, any symptoms?_________________		

Notes

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