JAMES STREET
DENTAL ARTS

Patient Name: _____

Birth Date: _____ **Date:** _____

Are you under physician's care? Date of last exam? ☐ Yes ☐ No If Yes: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If Yes: _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If Yes: _____

_____

_____

Have you taken bisphosphonates {Ie. Fosamax, Boniva) ☐ Yes ☐ No If Yes: _____

Have you taken cortisone (steroids) medications? ☐ Yes ☐ No If Yes: _____

Have you been recommended to take antibiotic premedication for dental treatment? ☐ Yes ☐ No If Yes: _____

Do you smoke or use tobacco products? ☐ Yes ☐ No If Yes: _____

Have you used controlled substances? ☐ Yes ☐ No If Yes: _____

Do you have difficulty reclining fully in a dental chair? ☐ Yes ☐ No If Yes: _____

Do you have any impairments or limitations?

☐ Visual ☐ Hearing ☐ Physical ☐ Cognitive

Have you ever experienced any of these complications prior to dental treatment?

☐ Prolonged bleeding ☐ Anesthetic reaction ☐ Fainting ☐ Dental Anxiety

☐ Other _____

Are you allergic to the following:

☐ Latex ☐ Local Anesthetic ☐ Penicillin/Amoxicillin ☐ Codeine ☐ Other _____

☐ Acrylic ☐ Sulfa drugs ☐ Aspirin ☐ Metal _____

Women: Are you:

☐ Pregnant ☐ Nursing ☐ Taking oral contraceptives ☐ Trying to get pregnant

Do you have, or have you had, any of the following:

AIDS/HIV Positve ☐Yes ☐No	Herpes ☐Yes ☐No	Shingles ☐Yes ☐No	Hepatitis A ☐Yes ☐No
Hepatitis B or C ☐Yes ☐No	Tuberculosis ☐Yes ☐No	Sexually Trans. Disease ☐Yes ☐No	Cold Sores ☐Yes ☐No
Easily Winded ☐Yes ☐No	Frequent Cough ☐Yes ☐No	Chest Pains ☐Yes ☐No	Bruise Easily ☐Yes ☐No
Excessive Bleeding ☐Yes ☐No	Fainting Spells/Dizziness ☐Yes ☐No	Frequent Headaches ☐Yes ☐No	Recent Weight Loss ☐Yes ☐No
Excessive Thirst ☐Yes ☐No	Swelling of Limbs ☐Yes ☐No	Anaphylaxis ☐Yes ☐No	Hives or Rash ☐Yes ☐No
Diabetes ☐Yes ☐No	Renal Dialysis ☐Yes ☐No	Kidney/Baldder Dis. ☐Yes ☐No	Stomach/Intes. Dis. ☐Yes ☐No
Liver Disease ☐Yes ☐No	Thyroid Disease ☐Yes ☐No	Ulcers ☐Yes ☐No	GERD ☐Yes ☐No
High Cholesterol ☐Yes ☐No	High Blood Pressure ☐Yes ☐No	Low Blood Pressure ☐Yes ☐No	Heart Trouble/Dis. ☐Yes ☐No
Heart Attack/Failure ☐Yes ☐No	Irregular Heartbeat ☐Yes ☐No	Cong. Heart Disorder ☐Yes ☐No	Heart Murmur/MVP ☐Yes ☐No
Angina ☐Yes ☐No	Stent Placement ☐Yes ☐No	Artificial Heart Valve ☐Yes ☐No	Pacemaker ☐Yes ☐No
Stroke ☐Yes ☐No	Aneurism ☐Yes ☐No	Emphysema/COPD ☐Yes ☐No	Lung Disease ☐Yes ☐No
Asthma ☐Yes ☐No	Blood Transfusion ☐Yes ☐No	Blood Disease ☐Yes ☐No	Anemia ☐Yes ☐No
Cancer ☐Yes ☐No	Chemo/Radiation ☐Yes ☐No	Organ Transplant ☐Yes ☐No	Artificial Joint ☐Yes ☐No
Osteoporosis ☐Yes ☐No	Rheumatoid Arthritis ☐Yes ☐No	Alzheimer/Dementia ☐Yes ☐No	Epilepsy or Seizures ☐Yes ☐No
Psychiatric Care ☐Yes ☐No	Drug Addiction ☐Yes ☐No	Parkinson's Disease ☐Yes ☐No	Sinus Trouble ☐Yes ☐No
Glaucoma ☐Yes ☐No	Gout ☐Yes ☐No		

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If Yes: _____

Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions

Signature Update 1

Has there been any changes in your medical conditions or medications? ☐ Yes ☐ No If Yes:_____

Signature of Patient, Parent or Guardian

X_____ Date _____

Signature Update 2

Has there been any changes in your medical conditions or medications? ☐ Yes ☐ No If Yes:_____

Signature of Patient, Parent or Guardian

X_____ Date _____

Signature Update 3

Has there been any changes in your medical conditions or medications? ☐ Yes ☐ No If Yes:_____

Signature of Patient, Parent or Guardian

X_____ Date _____

Signature Update 4

Has there been any changes in your medical conditions or medications? ☐ Yes ☐ No If Yes:_____

Signature of Patient, Parent or Guardian

X_____ Date _____

Signature Update 5

Has there been any changes in your medical conditions or medications? ☐ Yes ☐ No If Yes:_____

Signature of Patient, Parent or Guardian

X_____ Date _____

Signature Update 6

Has there been any changes in your medical conditions or medications? ☐ Yes ☐ No If Yes:_____

Signature of Patient, Parent or Guardian

X_____ Date _____

Signature Update 7

Has there been any changes in your medical conditions or medications? ☐ Yes ☐ No If Yes:_____

Signature of Patient, Parent or Guardian

X_____ Date _____

Signature Update 8

Has there been any changes in your medical conditions or medications? ☐ Yes ☐ No If Yes:_____

Signature of Patient, Parent or Guardian

X_____ Date _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Patient Information

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Soc. Sec.: _____

Email: _____ ☐ I would like to receive s=correspondences via email ☐ Text Messages

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc. Sec.: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.# or ID# _____ Insured Birth date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ State/City/Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.# or ID# _____ Insured Birth date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ State/City/Zip: _____

Dental History

Did someone refer you? ☐ Yes ☐ No If Yes:_____

Date of last dental visit? _____

What did you have done? _____

Please describe the reason for this visit: _____

What would best describe your past dental care: ☐ Routine ☐ Episodic ☐ Only when I have problems ☐ First visit

How would you describe your present oral condition?

☐ Good ☐ Fair ☐ Poor

Do you brush at least 2x per day? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Have you had radiation treatment to head or neck? ☐ Yes ☐ No

Those with dentures or partials, are they:

Comfortable? ☐ Yes ☐ No

Esthetically pleasing? ☐ Yes ☐ No

Over 10 years old? ☐ Yes ☐ No

Comment:_____

_____

_____

Do you currently experience any of the following:

- ☐ gag easily
- ☐ teeth sensitive to hot or cold
- ☐ teeth sensitive to sour
- ☐ dry mouth
- ☐ gums that bleed when brushing or flossing
- ☐ teeth sensitive to pressure
- ☐ floss that catches, frays or break
- ☐ trouble talking
- ☐ generally sensitive teeth
- ☐ teeth sensitive to sweets
- ☐ food that gets caught in teeth
- ☐ pain, soreness, or tenderness in any head or neck muscles
- ☐ awareness of noises in the jaw joint
- ☐ pain around the ears, temple, or cheeks
- ☐ previous jaw joint problem
- ☐ clenching or grinding
- ☐ pain when chewing or talking
- ☐ bite that feels uncomfortable or unusual
- ☐ pain or difficulty opening mouth
- ☐ jaws that get stuck
- ☐ frequent headaches

Patient, Parent, or Guardians Signature:_____ Date:_____