As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only, and will be kept confidential, subject to applicable laws. You may be asked additional questions about your responses, as such information is vital to provide appropriate care.

Patient Information

First Name: ___________________________ Middle Initial: _____ Last Name: ____________________________

Preferred Name: ____

Marital Status (please circle): Married Single Divorced Separated Widowed

Home Phone: (_____) ________________________ Business/Cell Phone: (_____) _________________________

Address: ____ City: ____________________ State: _____ Zip: ___________

Occupation: ____

Height: _______________ Weight: _______________ Date of Birth: ________________ Sex: ________________

Social Security Number: _____________________ Email Address: ___________________________________

Preferred Method of Contact (please circle): Home Work Cell Email

How Did You Hear About Our Office? ____

Emergency Contact: ____ Relationship: _________________________

Home Phone: (_____) ________________________ Business/Cell Phone: (_____) _________________________

Insurance Information

Subscriber Name: ____

Relationship to Patient (please circle): Self Spouse Child/other

Employer Providing Insurance Coverage: ____

Dental Insurance Company: ____

Subscriber ID Number: ____

Subscriber Social Security Number: __________________________ Date of Birth: _____________

I hereby authorize Schultz Family Dental to provide dental treatment for me, or my above-named child. I understand that I am ultimately responsible for my account with this office.

Patient Signature: ____ Date: ____________________

Dental Information

	Yes	No	NA
Do your gums bleed when you brush or floss?			
Are your teeth sensitive to cold, hot, sweets, Pressure/biting?			
Do you notice difficulty chewing?			
Is your mouth dry?			
Do you notice bad breath?			
Have you ever had any periodontal (gum) treatment?			
Have you ever had any orthodontic (braces) treatment?			
Have you had any problems associated with previous dental treatment?			
Is your home water supply fluoridated?			
Do you drink bottled or filtered water?			
Are you currently experiencing dental pain or discomfort?			
Do you have Headaches or neck pain?			
Do you have any clicking, popping, or discomfort in the Jaw?			
Do you grind or clench your teeth?			
Do you have sores or ulcers in your mouth?			
Do you wear dentures or partial dentures?			
Do you participate in active recreational activities?			
Have you ever had a serious injury to your head or mouth?			

Date of last dental exam: ____

Dental treatment completed at that time: ____

Date of last dental xrays: ____

How often do you brush? ___________________ How often do you Floss? ___________________

Do you use a mouthwash? ___________ If yes, what type? _______________________________________

Do you use an electric toothbrush? ___________ If yes, what type? _______________________

Do you smoke? ____________________ Do you chew tobacco? ______________________ Do you vape? __________________________

What is the reason for your visit today? ____

Are you happy with your smile? ____

Would you like for your teeth to be whiter? ____

Is there anything you'd like to change about your teeth/gums/oral health?

____

What type of dentistry would you like for us to recommend (please circle)?

Comprehensive Cosmetic Preventative Repairs only

How did you hear about our office? ____

Medical Information

	YES	NO	NA
Are you currently under the care of a physician?			

Date of Last Physical Exam: ____

Physician Name: ____

Address: ____ City: ___________________ State: _____ Zip: ___________

Business Phone: (_____) ________________________

	Yes	No	NA
Are you in good health?			
Have there been any significant changes to your health within the past year?			

If yes, what condition is being treated? ____

	Yes	No	NA
Have you had a serious illness, operation, or hospitalization within the past 5 years?			

If yes, what was the Illness or problem? ____

	Yes	No	NA
Are you currently taking any over-the-counter or prescription medications?			

If so, please list all medications and dosages below (including vitamins, herbal, and/or dietary supplements).

____

____

Joint Replacement	Yes	No	NA
Have you had an orthopedic full joint replacement (Hip, Knee, Elbow, Finger)?			

Date _______________ If so, have you had any complications? ____________________________________

Therapeutic Drugs	Yes	No	NA
Are you taking or scheduled to begin taking any anti-resorptive medications (such as Fosamax, Actonel, Atelvia, Boniva, Reclast, ProLia) for osteoporosis or Paget's Disease?			
Are you taking or scheduled to begin taking any anti-resprotive medications (such as Aredia, Zometa, XGEVA) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?			

Allergies	Yes	No	NA
Local Anesthetics			
Aspirin			
Penicillin or other Antibiotics			
Barbiturates, Sedatives, or Sleeping PIlls			
Sulfa Drugs			
Codeine or other Narcotics			
Metals			
Latex/Rubber			
Iodine			
Hay Fever/Seasonal			
Animals			
Food			
Other			

Medical Conditions	Yes	No	NA
Artificial/Prosthetic Heart Valve			
Previous Infective Endocarditis			
Damaged Valves in Transplanted Heart			
Congenital Heart Disease (CHD)			
Unrepaired, Cyanotic CHD			
Repaired (completely) in Last 6 months			
Repaired CHD (with residual effects)			

**If any of the above conditions apply, antibiotic prophylaxis is recommended prior to completion of dental procedures.*

Medical Conditions	Yes	No	NA
Cardiovascular disease			
Angina			
Arteriosclerosis			
Congestive Heart Failure			
Damaged Heart Valves			
Heart Murmur			
Heart Attack			
Low Blood Pressure			
High Blood Pressure			
Mitral Valve Prolapse			
Pacemaker			
Rheumatic Fever			
Rheumatic Heart Disease			
Abnormal Bleeding			
Anemia			
Sickle Cell Anemia			
Blood Transfusion			
Blood Disorder			
Hemophilia			
HIV/AIDS			
Arthritis			
Autoimmune Disease			
Rheumatoid Arthritis			
Systemic Lupus Erythematosus			
Cortisone Treatment			
Circulatory Problems			
Asthma			
Bronchitis			
Sinus Trouble			
Tuberculosis			
Cancer/Chemotherapy/Radiation Treatment			
Chest Pain Upon Exertion/shortness of breath			
Chronic Pain			
Diabetes (Type I or II)			
Eating Disorder			
Emphysema or other respiratory illness			
Epilepsy or Seizures			
Fainting			
Malnutrition			
Gastrointestinal Disease			
G.E. Reflux/Persistent Heartburn			
Ulcers			
Thyroid Problems			
Stroke			
Glaucoma			
Hepatitis, Jaundice, or Liver Disease			
Epilepsy			

Fainting Spells			
Neurological Disorders			
Sleep Disorder			
Snoring			
Mental Health Disorders			
Recurrent Infections			
Kidney Problems			
Night Sweats			
Osteoporosis			
Persistent Swollen Glands in Neck			
Tonsillitis			
Severe Headaches/Migraines			
Severe or Rapid Weight Loss			
Sexually Transmitted Disease			
Excessive Urination			
Back Problems			

Please explain any of the above responses as needed.

____
____
____
____
____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

____

Do you have any condition or problem not listed above that we should know about?

____

Women Only

Are you pregnant? __________________________ If so, how many weeks? ___________________________

Are you taking birth control pills or hormone replacement? _________________________

Are you nursing? ____

I certify that I have read and understand the form above, and that the information given on this form is accurate to the best of my knowledge. I understand that this information is necessary to provide me with dental care in a safe and efficient manner, and that it will remain confidential, and only used to improve communication and care as it pertains to my dental treatment. I will not hold Schultz Family Dental responsible for any action taken or not taken because of errors and/or omissions made in the completion of this form. It is my responsibility to inform my dental office of any changes to my medical status.

Signature of Patient/Legal Guardian: ___________________________ Date: _________________________________

Signature of Dentist: ____Date: ________________________