Southland Dental Care

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Chart#: 000880
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** _____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Whom may we thank for referring you to our practice? _____

Do your gums bleed when you brush or floss? ◯ Yes ◯ No

Are your teeth sensitive to cold, hot, sweets or pressure? ◯ Yes ◯ No

Is your mouth dry? ◯ Yes ◯ No

Have you had any periodontal (gum) treatments? ◯ Yes ◯ No

Have you ever had orthodontic (braces) treatment? ◯ Yes ◯ No

Have you had any problems associated with previous dental treatment? ◯ Yes ◯ No

Are you currently experiencing dental pain or discomfort? ◯ Yes ◯ No

Do you have earaches or neck pains? ◯ Yes ◯ No

Do you have clicking, popping or discomfort in the jaw? ◯ Yes ◯ No

Do you brux (grind) teeth? ◯ Yes ◯ No

Do you have sores or ulcers in your mouth? ◯ Yes ◯ No

Do you wear dentures or partials? ◯ Yes ◯ No

Have you ever had a serious injury to your head or mouth? ◯ Yes ◯ No

Date of your dental exam: _____

What was done at that time?

_____

_____

Date of last dental x-rays: _____

What is the reason for your dental visit today?

_____

_____

- ☐ Abnormal bleeding
- ☐ Allergy:Codeine
- ☐ Angina
- ☐ Blood Transfusion
- ☐ Congen Heart Defect
- ☐ Diabetes Type I
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Lupus
- ☐ Osteopenia
- ☐ Pre-Med Clindamycin
- ☐ Rheumatoid Arthiriti
- ☐ Tuberculosis
- ☐ AIDS/HIV infection
- ☐ Allergy:Erythromycin
- ☐ Asthma
- ☐ Cancer
- ☐ CongenHeartDisease
- ☐ Diabetes Type II
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ MentalHealthDisorder
- ☐ Osteoporosis
- ☐ Pre-Med Other
- ☐ See Clinical Notes
- ☐ Allergy:Amoxicillin
- ☐ Allergy:Latex
- ☐ Automimmune Disease
- ☐ Cardiovascular disea
- ☐ CongestHeartFailure
- ☐ Epilepsy
- ☐ Hemophilia
- ☐ Liver Disease
- ☐ MitralValveProlapse
- ☐ Pace Maker
- ☐ Rheum Heart Disease
- ☐ Seizures
- ☐ Allergy:Barbiturates
- ☐ Allergy:Local Anesth
- ☐ Bisphosphonates
- ☐ Chemotherapy
- ☐ Damaged Heart Valves
- ☐ Fainting Spells
- ☐ Hepatitis
- ☐ Low Blood Pressure
- ☐ None
- ☐ Pre-Med Amoxicillin
- ☐ Rheumatic fever
- ☐ Stroke

Please check your response to indicate if you have or have not had any of the following diseases or problems

Artificial(prosthetic) heart valve ◯ Yes ◯ No

Previous infective endocarditis ◯ Yes ◯ No

Congenital heart disease(CHD) ◯ Yes ◯ No

Women Only:

Are you pregnant? ◯ Yes ◯ No

Number of weeks: _____

Nursing? ◯ Yes ◯ No

Taking birth control pills or hormonal replacement ◯ Yes ◯ No

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Are you under the care of a physician? ◯ Yes ◯ No

Physician Name:

_____

_____

Phone: Include area code _____

Address/City/ State/Zip:

_____

_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment ◯ Yes ◯ No

Name of physician or dentist making recommendation: _____

Phone: Include area code _____

Are you in good health? ◯ Yes ◯ No

Has there been any change in your general health within the past year?
If yes, what condition is being treated? ◯ Yes ◯ No

_____

_____

Have you had a serious illness, operation or been hospitalized in the past 5 years?
If yes, what was the illness or problem? ◯ Yes ◯ No

_____

_____

Are you taking or have you recently taken any prescription or over the counter medicine(s) ◯ Yes ◯ No

Please list ALL, including vitamins, natural or herbal preparations and/or dietary supplements:

_____

_____

Joint Replacement:
Have you had an orthopedic total joint (hip,knee,elbow,finger) replacement? ◯ Yes ◯ No

Date: _____

If yes, have you had any complications?

_____

_____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax*, Actonel*, Atelvia*, Boniva*, Reclast*, Prolia*) for osteoporosis or Paget's disease?

◯ Yes ◯ No

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia*, Zometa*, XGEVA*) for bone pain, hypercalcemia or skeltal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

◯ Yes ◯ No

If yes, please enter date the treatment began: _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on the information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Please check if you approve

☐ Voicemail/Answering Machine

☐ Results of lab test/xrays

☐ Other/Family billing, Financial, Dental/Medical Information

Ok to give absentee information to Employer (Provide Name)

_____

_____

Ok to give absentee information to School (Provide Name)

_____

_____

Ok to provide information to Spouse (Provide Name)

_____

_____

Ok to provide information to Parent(s) (Provide Name)

_____

_____

Ok to provide information to Other (Provide Name)

_____

_____

Signature of Patient/Legal Guardian:

Signature _____ **Date** _____

Response Date: ___/___/_____