HINNANT FAMILY DENTISTRY

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

How did you hear about us/Referred to us by: _____

ADULT HEALTH HISTORY

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

	Yes	No
Artificial (prosthetic) heart valve? _____	☐	☐
Valve repair with prosthetic material? _____	☐	☐
Previous infective endocarditis? _____	☐	☐
Congenital heart disease (CHD)		
Unrepaired, cyanotic CHD _____	☐	☐
Repaired (completely) in last 6 months _____	☐	☐
Repaired CHD with residual defects _____	☐	☐

WOMEN ONLY – Are you:	Yes	No
Pregnant? _____	☐	☐
Number of weeks: _____		
Taking birth control pills or hormone replacement? __	☐	☐
Nursing? _____	☐	☐

Allergies – Are you allergic to or have you had a reaction to:

	Yes	No		Yes	No
Local anesthetics _____	☐	☐	Sulfa drugs or Iodine _____	☐	☐
Latex/Rubber _____	☐	☐	Metals _____	☐	☐
Aspirin _____	☐	☐	Codeine or other narcotics _____	☐	☐
Penicillin _____	☐	☐	Epinephrine _____	☐	☐
Other Antibiotics _____	☐	☐	Other Allergies _____	☐	☐
Barbiturates, sedatives or sleeping pills_____	☐	☐			

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

	Yes	No
Diabetes? _____	☐	☐
Last HbA1c date and level _____		
Taking Blood Thinners _____	☐	☐
Pacemaker _____	☐	☐
Heart Attack _____	☐	☐
Year:		
Mitral Valve Prolapse _____	☐	☐
Rheumatic Heart Disease _____	☐	☐
Other Heart Condition _____	☐	☐
High Blood Pressure _____	☐	☐
Low Blood Pressure _____	☐	☐
Stroke _____	☐	☐
Year:		
Fainting spells or Seizures _____	☐	☐
Epilepsy _____	☐	☐
Herpes or other STD _____	☐	☐
HIV-positive/AIDS _____	☐	☐
Prolonged Bleeding Disorder _____	☐	☐
Autoimmune Disease _____	☐	☐

	Yes	No
Gastrointestinal Condition _____	☐	☐
Joint Replacement _____	☐	☐
Year: _____ Any complications? _____		
Eating Disorder _____	☐	☐
Asthma _____	☐	☐
Emphysema _____	☐	☐
Cancer/Chemotherapy/Radiation Treatment _____	☐	☐
Year Diagnosed:		
Kidney Problems/Dialysis _____	☐	☐
Hepatitis, Jaundice or Liver Disease_____	☐	☐
Thyroid Problem _____	☐	☐
Tuberculosis _____	☐	☐
Year: Txt:		
Dementia/Alzheimer's Disease _____	☐	☐
Arthritis _____	☐	☐
Osteoporosis/treatment with Bisphosphonates ____	☐	☐
Neurological or Mental Health Disorder _____	☐	☐
History of alcohol or drug abuse _____	☐	☐
Hearing Impaired _____	☐	☐
Other _____	☐	☐

MEDICAL INFORMATION

	Yes	No		Yes	No
Are you currently under the care of a physician?	☐	☐	Physician Name: Phone:		
Have you had a serious illness, operation or been hospitalized in the past 5 years? Why?_____	☐	☐	Address/City/State/Zip:		
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	Date of last physical exam:		
Do you use controlled substances (drugs)? _____	☐	☐	Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐
Do you drink alcoholic beverages? _____	☐	☐	If yes, please indicate which one(s), daily frequency & how long? _____		
If yes, how much alcohol do you drink in 1 week? _____					

	Yes	No
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis? _____	☐	☐
Have you been treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia, Zometa or Prolia) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? _____	☐	☐

Are you taking any medications/drugs/pills/supplements? If so, please list: _____

_____

_____

_____

ADULT DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment? ____	☐	☐
Are you interested in sedation dentistry? _____	☐	☐
Have you had any problems associated with previous dental treatment? _____	☐	☐
Do you gag easily? _____	☐	☐
Do you wear dentures or partials? _____	☐	☐
Does food catch between your teeth? _____	☐	☐
Do you have difficulty chewing your food? _____	☐	☐
Do your gums bleed when you floss? _____	☐	☐
Have you ever noticed slow-healing sores in or about your mouth? _____	☐	☐
Is your mouth dry? _____	☐	☐
Are your concerned with bad breath (malodor)? ___	☐	☐
Are your teeth sensitive to: ☐ Nothing ☐ Cold ☐ Heat ☐ Sweet ☐ Pressure		
Is your home water supply fluoridated? _____	☐	☐
Do you drink bottled or filtered water? _____	☐	☐

	Yes	No
Do you prefer to save your teeth? _____	☐	☐
Do you want complete dental care? _____	☐	☐
How often do you brush? _____times/day		
How often do you floss? _____times/day		
Have you had any periodontal (gum) treatments? __	☐	☐
Have you ever had orthodontic treatment (braces)?	☐	☐
Do you have any clicking, popping or discomfort in the jaw? _____	☐	☐
Do you clench or grind your teeth? _____	☐	☐
Do you wear a bite guard? _____	☐	☐
Have you ever had a serious injury to your head or mouth? _____	☐	☐
Are you concerned with snoring or sleep apnea? __	☐	☐
Date of your last dental exam: _____		
What was done at that time? _____		
Date of last dental x-rays: _____		

What is the reason for your dental visit today? _____

Are you dissatisfied with the appearance of your teeth? If yes, please explain. ☐ ☐

_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the information that I have provided on this form is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions made in the completion of this form. I understand that it is my responsibility to inform my doctor if I have a change in health.

Patient/Guardian Signature _____ Date _____