THE COLONIES
DENTAL CENTER

Patient Information

Name:	Birth Date:	SSN:	
Address:	City:	State:	Zip:
Drivers License #	Issuing State:		
Home Phone:	Cell Phone:	☐ Male	☐ Female
Employer:			
Is Patient a dependent child?	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
Spouse Name:	Spouse Birth Date:	Spouse's SSN:	
Emergency Contact: Name:	Relationship:	Cell:	Home: Work:
Name:	Relationship:	Cell:	Home: Work:

Dental History

Why have you come to see us today (pain, check up, etc)

Previous Dentist: Date of Last Cleaning: Date of Last Radiographs:

Are you nervous about seeing the dentist: ☐ Yes ☐ No If yes, please tell us why:

1. Y N I clench or grind my teeth during the day or while sleeping.
2. Y N My gums bleed while brushing or flossing.
3. Y N I have problems eating.
4. Y N I have had facial or jaw injuries
5. Y N I avoid brushing part of my mouth due to pain.
6. Y N My gums feel tender or swollen
7. Y N I want my teeth whiter

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

1. Y N Heart Disease
2. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Abnormal Blood Pressure
6. Y N Anemia
7. Y N Tuberculosis or Lung Disease
8. Y N Asthma
9. Y N Sinus Trouble
10. Y N Epilepsy/Seizures
11. Y N Ulcers / GERD
12. Y N Implants/Artificial Joints: _____ Orthopedic Surgeon: _____
13. Y N I smoke or use tobacco. How many years? _____ If yes, how much per day? _____
14. Y N Have you ever taken Fen-Phen or Redux?
15. Y N I have had major surgery:

Year: _____ Type of operation: _____
Year: _____ Type of operation: _____

19. Y N Liver Disease
21. Y N Hepatitis Type ____.
22. Y N Diabetes
26. Y N Arthritis
27. Y N Sexually Transmitted Disease
28. Y N Kidney Disease
30. Y N Cancer/Chemotherapy
31. Y N Radiation Treatment
32. Y N History of Drug Addiction
34. Y N Immune Suppressed Disorder
35. Y N Hearing Loss
36. Y N Fainting Spells
37. Y N Glaucoma
38. Y N History of Emotional or Nervous Disorders

WOMEN

39. Y N Are you taking birth control medication?
40. Y N Are you or could you be pregnant or nursing?

Do you have any other conditions that are not listed above _____
_____
_

Do you have any allergies_____
_____
_

Please list all medications you are taking:

Medicine: _____ Dose: _____
Medicine: _____ Dose: _____
Medicine: _____ Dose: _____
Medicine: _____ Dose: _____
Medicine: _____ Dose: _____
Medicine: _____ Dose: _____