DENTAL ASSOCIATES OF DELAWARE

Patient Personal Information

Title _____ Nickname _____
Last, First _____
Address _____
City, State, Zip _____
Email _____

Birth Date _____
Marital Status _____
Home # _____
Cell # _____
Student _____
School Name _____
Referral Type _____

Age _____
Sex _____
Work # _____
Drivers License _____
SSN _____

Person Responsible/Guarantor for Paying Bills

Title _____
Last, First _____
Address _____
City, State, Zip _____
Email _____

Birth Date _____
SSN _____
Drivers License # _____
Phone # _____

Preferred Contact Method: Telephone Call ❑ Email ❑ Text Message ❑

Do You have Primary Dental Insurance? ❑ Yes ❑ No

Group No / Name _____
Insurance Company _____
Phone # _____
Employer Name _____
Subscriber Last, First _____
Subscriber Address _____
City, State, Zip _____
Relationship to Patient _____ D.O.B. _____
Subscriber ID _____

Do You have Secondary Dental Insurance? ❑ Yes ❑ No

Group No/Name _____
Insurance Company _____
Phone # _____
Employer Name _____
Subscriber Last, First _____
Subscriber Address _____
City, State, Zip _____
Relationship to Patient _____ D.O.B. _____
Subscriber ID _____

Emergency Contact

Name: _____ **Phone Number:** _____ **Relationship to Patient:** _____

Patient Medical Information

Allergic To:

- ❑ Antibiotics: _____
- ❑ Aspirin
- ❑ Epinephrine
- ❑ Food Allergy
- ❑ Iodine
- ❑ Latex Rubber
- ❑ Local Anesthetics
- ❑ Metals
- ❑ Milk / Dairy
- ❑ Other Allergies Not Listed: _____

Check, if applicable:

- ❑ AIDS / HIV Infection
- ❑ Alcohol Abuse / Addiction
- ❑ Anemia
- ❑ Anorexia / Bulimia
- ❑ Arthritis
- ❑ Asthma
- ❑ Autoimmune Disease
- ❑ Bisphosphonate Therapy / Fosamax
- ❑ Bleeding Problems
- ❑ Blood Transfusion
- ❑ Bronchitis
- ❑ Cancer / Tumor or Growth
- ❑ Cardiac Pacemaker
- ❑ Chemo / Radiation
- ❑ Chest Pain
- ❑ COPD
- ❑ Developmental Disability
- ❑ Diabetes
- ❑ Drug Abuse / Addiction
- ❑ Dry Mouth
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting Spells
- ❑ Fever Blisters / Herpes
- ❑ Gastrointestinal Disease
- ❑ Hay Fever
- ❑ Headaches / Migraines
- ❑ Heartburn / Reflux
- ❑ Heart Attack - Date: _____
- ❑ Heart Disease
- ❑ Hepatitis / Jaundice
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hives / Skin Rash
- ❑ HPV
- ❑ Joint Replacement
- ❑ Kidney Disease
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Osteoporosis
- ❑ Premedication Required
- ❑ Psychiatric Disorder
- ❑ Seizures
- ❑ Shortness of Breath
- ❑ Sinus Trouble
- ❑ Sjogrens Syndrome
- ❑ Sleep Apnea
- ❑ Snoring
- ❑ Stroke - Date: _____
- ❑ Thyroid Problems
- ❑ Tuberculosis (Active)
- ❑ Valve Replacement / Damage

Medical Questionnaire

Name of Family Physician: _____ Phone: _____

❑ Yes ❑ No Are you currently under care of a Physician?
*If Yes, what is the condition being treated? _____

❑ Yes ❑ No Have you had any serious illness, operation or been hospitalized within the past 5 years?
*If Yes, what illness or problem? _____

❑ Yes ❑ No Are you currently taking any medication(s)?
*If Yes, what? _____
*If necessary, please provide list of additional medications

❑ Yes ❑ No Do you drink alcoholic beverages?
*If Yes, how many drinks per week? _____

❑ Yes ❑ No Do you vape, smoke or chew tobacco?
*If Yes, which and frequency? _____

❑ Yes ❑ No Are you pregnant?
*If Yes, when is your due date? _____

❑ Yes ❑ No Are you currently nursing?

❑ Yes ❑ No Are you on birth control pills?

❑ Yes ❑ No Do you use any controlled substances? *If Yes, name(s) and frequency: _____

DENTAL ASSOCIATES OF DELAWARE

Dental Questionnaire

Name of previous Dentist: _____ Phone: _____

Date of your last cleaning: _____ Last exam date: _____

Date of your last full series of x-rays: _____ Why are you visiting us today? _____

❑ Yes ❑ No Do you premedicate before your dental appointments?

❑ Yes ❑ No Are you happy with your smile?

❑ Yes ❑ No Are you having any specific problems with your teeth, gums, or mouth at this time?

❑ Yes ❑ No Do you have problems with teeth / fillings breaking?

❑ Yes ❑ No Do you want whiter teeth?

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

❑ Yes ❑ No Have you ever been told you have gum disease?

❑ Yes ❑ No Do your gums bleed while brushing or flossing?

❑ Yes ❑ No Do you regularly use dental floss?

❑ Yes ❑ No Do you clench or grind your teeth?

❑ Yes ❑ No Do you have difficulty in opening your mouth widely?

❑ Yes ❑ No Do you notice popping, clicking or soreness of the jaws or points just in front of the ears?

❑ Yes ❑ No Do you wear a night guard?

❑ Yes ❑ No Have you had any head, neck or jaw injuries?

❑ Yes ❑ No Do you have unpleasant taste or odor in your teeth / mouth?

❑ Yes ❑ No Does food catch between your teeth?

❑ Yes ❑ No Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth?

❑ Yes ❑ No Have you ever had burning of the tongue or cracking of the corners of your mouth?

❑ Yes ❑ No Have you ever had orthodontic treatment? If Yes, date of placement: _____

❑ Yes ❑ No Do you wear dentures or partials? If Yes, date of placement: _____

❑ Yes ❑ No Are you happy with your dentures?

Additional Comments: _____

_____

By signing below, I certify that all the above information is true to the best of my knowledge.

_____ _____

Patient / Guardian Signature Date