Freeman Dental, PLLC

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Chart#: _____
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: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

SSN: _____

Please list below an Emergency Contact. (Name, Phone Number, and Relationship)

_____

_____

Please list your primary physician name and phone number.

_____

_____

If you are completing this form for another person, what is your relationship to that person?

_____

_____

I hereby allow Freeman Dental PLLC to release protected health information to the entities or family members named below.

_____

_____

Whom may we thank for referring you to our practice?

☐ Commercial ☐ Internet ☐ Other (name below):

_____

Medical History

Please List below any current medications you are taking, including vitamins, natural or herbal supplements, dietary supplements, and any over the counter medications.

_____

_____

_____

_____

Please check if any apply:

- ☐ Active Tuberculosis?
- ☐ Cough that produces blood?
- ☐ None of these apply
- ☐ Persistant cough greater than a 3 week duration?
- ☐ Been exposed to anyone with Tuberculosis?

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosomax, 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 skelatal complications resulting from Paget's disease, multiple myeloma or metastic cancer?

◯ Yes ◯ No

What is the date treatment began? _____

Do you take antibotic premedication for your dental visits? ◯ Yes ◯ No

Name of physician and their specialty:

_____

_____

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

What joint was replaced? What date was the joint replaced? Have you had any complications?

_____

_____

Please mark any that apply with a checkbox. Except for the conditions listed below, antibiotic prophylaxis is no longer recommended for any other form of congenital heart disease.

- ☐ Artificial (prosthetic) heart valve
- ☐ Congenital Heart Disease (CHD)
- ☐ Repaired CHD with residual defects
- ☐ Previous infective endocarditis
- ☐ Unrepaired cyanotic CHD
- ☐ NONE OF THESE APPLY
- ☐ Damaged valves in transplanted heart
- ☐ Repaired (completely) in last 6 months

Please mark any that apply with a checkmark. Are you allergic to or have you had a reaction to any of the following:

- ☐ Local Anesthetics
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Metals
- ☐ Hay fever / Seasonal
- ☐ Other
- ☐ Aspirin
- ☐ Sulfa Drugs
- ☐ Latex (Rubber)
- ☐ Animals
- ☐ OR NO KNOWN ALLERGIES
- ☐ Penicillin or other antibiotics
- ☐ Codeine or other narcotics
- ☐ Iodine
- ☐ Food

If any condition or alert selected above needs further clarification, please explain below:

_____

_____

Indicate which of the following you have had or have at present. By checking the box it will indicate a "YES" response. Leaving the box blank will indicate a "NO" response.

- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Disease
- ☐ Congenital heart dis
- ☐ Dizziness
- ☐ Fainting
- ☐ Head Injuries
- ☐ Hemophilia
- ☐ Kidney Problems
- ☐ Mental Disorders
- ☐ Osteoporosis
- ☐ Pregnancy
- ☐ Rheumatic Fever
- ☐ STD Disease
- ☐ Thyroid problems
- ☐ ADHD
- ☐ Arthritis
- ☐ Autistic
- ☐ Blood Thinner
- ☐ Congestive heart fai
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Latex Allergy
- ☐ Mitral Valve Prolaps
- ☐ Other
- ☐ Pre-Med
- ☐ Rheumatism
- ☐ Stomach Problems
- ☐ Tuberculosis
- ☐ AIDS or HIV
- ☐ Artificial Heart Val
- ☐ Autoimmune Disease
- ☐ Cancer
- ☐ Deaf
- ☐ Epilepsy
- ☐ Growths
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Seizures/Fainting
- ☐ Stroke
- ☐ Tumors
- ☐ Allergies
- ☐ Artificial Joints
- ☐ Bipolar
- ☐ Codeine Allergy
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Hay Fever
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ Low blood pressure
- ☐ Neurologic Disorders
- ☐ Penicillin Allergy
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Systemic Lupus
- ☐ Ulcers

Mark any that apply:

- ☐ Ever been hospitalized (illness or injury)
- ☐ Do you use tobacco (smoke or chew)
- ☐ FEMALE: Currently Pregnant
- ☐ None of these apply
- ☐ Taking dietary supplements
- ☐ Do you use controlled substances (drugs)
- ☐ FEMALE: Currently Nursing/Breastfeeding
- ☐ Do you drink alcoholic beverages
- ☐ Presently being treated for any other illnesses
- ☐ FEMALE: Taking birth control pills

If any condition or alert selected above needs further clarification, please explain below:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

_____

_____

☐ **By checking this box, I acknowledge the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

Signature _____ **Date** _____

Previous Dentist name and how long have you been a patient there: _____

Date of most recent dental exam and x-rays: _____

What is your immediate concern?

_____

_____

Are you fearful of dental treatment? How fearful, on a scale of 1(least) to 10(most) _____

Personal History, Check all that apply:

☐ Had complications from past dental treatment ☐ Had/Have braces, orthodontic treatment ☐ Do you drink bottle water or filtered water

Smile Characteristics, Check all that apply:

☐ Is there anything about the apperance of your teeth that you would like to change?

☐ Have you ever whitened (bleached) your teeth?

☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?

☐ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

☐ You have problems with your jaw joint

☐ You clench your teeth in the daytime or make them sore

☐ You have problems with crowding or developing spaces

☐ You wear or have worn a bite appliance

Patient Information

Tooth structure, Check all that apply:

☐ Do you have dry mouth

☐ Any teeth sensitive to hot, cold, sweets, or you avoid brushing any part of your mouth

☐ Food gets caught between any teeth

☐ Are you currently experiencing dental pain or discomfort

☐ Do you have sores or ulcers in your mouth

Gum and Bone, Check all that apply:

☐ Gums bleed when brush or floss

☐ Noticed an unpleasant taste or odor in your mouth

☐ Experienced gum recession

☐ Treated for gum disease or were told you have bone loss

☐ History of periodontal disease in your family

Are you interested?

☐ Botox ☐ Teeth Whitening ☐ Invisalign ☐ Sedation

If any of the checked boxes need further explanation, please describe:

_____

_____

☐ **By checking this box, I acknowledge the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

Signature _____ **Date** _____

Response Date: ___/___/_____