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ADVANCED DENTAL RESTORATIONS, LLC

Welcome

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential) Today's Date:_____

How did you hear about us?_____

Patient's Name:_____ Preferred Name:_____

Address:_____City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____Email:_____

Date of Birth:_____ Social Security Number:_____

Employer:_____ Phone Number:_____

Preferred contact method for appointment reminders: Email Phone call Mail Text

Gender: Male_____ Female_____ Marital Status: Single_____ Married_____ Divorced_____ Widowed_____ Child_____

Emergency Contact Name:_____ Phone:_____

Responsible Party (If other than self)

Name:_____ Preferred Name:_____

Address:_____City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____Email:_____

Date of Birth:_____ Social Security Number:_____

Employer:_____ Phone Number:_____

Insurance Information

Insurance Carrier: _____ Phone: _____

Carrier Address: _____

Group Name:_____ Group Number:_____

Subscriber Name:_____ Date of Birth:_____

Social Security Number or Subscriber ID:_____ Relationship to Patient:_____

Patient Medical and Dental History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Medical Information

1) Physician:_____

Office phone:_____ Date of Last Exam:_____

2) Are you under medical treatment now? Yes No

If yes, please explain:_____

3) Are you taking any medications, prescriptions or non-prescriptions? Yes No

If yes, please list:_____

4) Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other: _____ If yes, please explain reaction:_____

5) Do you smoke or use smokeless tobacco? Yes No

Have you ever smoked or used smokeless tobacco? Yes No

If yes, indicate how much and how often:_____

6) Do you consume alcohol? Yes No

If yes, please indicate how much and how often:_____

7) Women: Are you Pregnant? Yes _____ months No Nursing? Yes No

8) Are you required to take an antibiotic prior to dental treatment (ex: for artificial joints, heart murmur, etc.)?

_____

9) Do you have or have you had any of the following? Please circle "Yes" or "No".

Heart (surgery, disease, attack)	Yes	No	Osteoporosis/Osteopenia	Yes	No	Cancer	Yes	No
Chest Pain	Yes	No	Respiratory Problems	Yes	No	Tumors	Yes	No
High Blood Pressure	Yes	No	Emphysema	Yes	No	Radiation Therapy	Yes	No
Mitral Valve Prolapse	Yes	No	Asthma	Yes	No	Chemotherapy	Yes	No
Heart Murmur	Yes	No	Liver Disease	Yes	No	Frequent Headaches	Yes	No
Stroke	Yes	No	Hepatitis / Jaundice	Yes	No	Neurological Disorders	Yes	No
Arthritis / Rheumatism	Yes	No	Thyroid Problems	Yes	No	Epilepsy or Seizures	Yes	No
Artificial Joints	Yes	No	Kidney Problems	Yes	No	Fainting or Dizzy Spells	Yes	No
(hip, knee, etc.) list type:	_____		Diabetes Type I or II	Yes	No	Nervous / Anxious	Yes	No
Sinus Trouble / Allergies	Yes	No	Diet (special/restricted)	Yes	No	Psychiatric/Psychological Care	Yes	No
			AIDS or HIV infection	Yes	No			

10) Do you have or have you had any disease, conditions, or problems not listed? Yes No

If yes, please explain:_____

Dental Information

1.) What is the reason for your visit today?_____

2.) What are your present dental problems?_____

3.) Date of last dental visit:_____ Dental Cleaning:_____ Dental X-ray:_____

4) Do you have any sores or lumps in or near your mouth?_____

If yes, please explain:_____

5.) Have you had any head, neck or jaw injuries?_____

If yes, please explain:_____

_____

Please circle Yes or No.

6.) Do you clench or grind your teeth?	Yes	No
7.) Do you bite your lips or cheeks frequently?	Yes	No
8.) Have you ever experienced any of the following problems in your jaw?		
• Clicking or Popping	Yes	No
• Difficulty in opening or closing	Yes	No
• Pain (joint, ears, or side of face)	Yes	No
9.) Do your gums bleed while brushing or flossing?	Yes	No
10.) Are your teeth sensitive to hot or cold liquids or foods?	Yes	No
11.) Are your teeth sensitive to sweet or sour liquids or foods?	Yes	No
12.) Do you have any pain in any teeth?	Yes	No
13.) Have you noticed any mouth odors or bad tastes?	Yes	No
14.) Have you noticed any loose teeth or changes in your bite?	Yes	No
15.) Have you ever had periodontal treatment?	Yes	No
16.) Are you satisfied with your teeth's appearance?	Yes	No
17.) Do you feel nervous about having dental treatment?	Yes	No

If yes, what is your biggest concern?_____

_____

I understand the above information is necessary to provide dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the receptive health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

_____

Print Name

_____

Patient/ Guardian Signature ***Date***