Happy Rock Dental

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Patient Information

Date_____ Referred by_____

Name_____Preferred name_____

(last) (first) (MI)

Address_____City_____State_____Zip_____

Best contact number? H/M/W Home_____Mobile_____Work_____

Email address_____ SSN_____

DOB_____ Gender M / F Occupation_____

Marital Status_____ Name of spouse or parent_____

Dental History

Reason for today's visit _____last visit?_____

Please check if you have any of the following:

_____bad breath
_____bleeding gums
_____blisters on tongue, mouth or throat
_____tobacco use
_____jaw clicking, pain or popping
_____dry mouth
_____food collection between teeth
_____grinding teeth
_____swollen or tender gums
_____loose teeth or broken fillings
_____orthodontic treatment
_____periodontal treatment
_____sensitivity to cold
_____sensitivity to heat
_____sensitivity to sweets
_____sensitivity when biting

How often do you brush?_____ How often do you floss?_____ Dentures? _____

Any problems with previous dental treatment? If so, please explain_____

Health History

Name of Physician_____

Please list ALL medications and correlating diagnosis:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Pharmacy name and location_____

Allergies: Penicillin___Codeine___Latex___Local Injected Anesthetics___Sulfa drugs___Other_____

DO YOU HAVE OR HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING?

____Abnormal blood pressure,high/low
____Arthritis
____Artificial joint replacement
____Epilepsy/Seizures
____Heart murmur
____Heart attack
____Pacemaker
____Stroke
____AIDS/HIV Positive
____Artificial heart valve/stints
____Cancer, radiation/chemo
____Fainting spells
____Hepatitis/type___
____Mitral Valve Prolapse
____Rheumatic Fever
____Tuberculosis/Lung disease
____Anemia
____Asthma
____Diabetes
____Glaucoma
____Hemophilia
____Osteoporosis
____Snoring problem
____Tumor/growth head,neck

Any other condition we should know about?

Pregnant?___ Due date:_____ Nursing?___

X_____ Date_____

(signature of patient or parent if minor)