WELCOME to PUTNAM DENTAL ASSOCIATES

PATIENT INFORMATION

Today's Date ____/____/____ Child ☐ Single ☐ Married ☐ Other ☐__________

Date of Birth ____/____/____ Sex: Male ☐ Female ☐

Social Security # _____-______-______ Email address: ________________________________

Patient Name: _______________________________ Referred by: _______________________

Address: ____

City/State/Zip ____

Main Contact Number _____________________________ Home / Cell / Work

Other Contact Number _____________________________ Home / Cell / Work

EMERGENCY CONTACT

Name/Relationship _________________________________ Phone # __________________________

Reason for today's visit: ____________________

Primary Physician:__________________________

Telephone #____________________________

City/State ____________________________

Prior Dentist: ___________________________

Telephone # ___________________________

Last Visit ____________ Last x-rays__________

DENTAL HISTORY

Y	N		Y	N	
☐	☐	Bad breath	☐	☐	Burning sensation
☐	☐	Dry mouth	☐	☐	Mouth pain
☐	☐	Bleeding gums	☐	☐	Ortho treatment
☐	☐	Grinding teeth	☐	☐	Food collection
☐	☐	Fingernail biting	☐	☐	Sensitive to heat
☐	☐	Pain around ear	☐	☐	Sensitive to cold
☐	☐	Mouth sore/growth	☐	☐	Sensitive to sweets
☐	☐	Smoking (tobacco)	☐	☐	Jaw clicking/popping
☐	☐	Chew on one side	☐	☐	Gums swollen/tender
☐	☐	Jaw pain	☐	☐	Perio treatment
☐	☐	Sensitivity when biting	☐	☐	Lip/cheek biting

GENERAL HEALTH: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

ALLERGIES/ALLERGIC REACTIONS: ☐ Aspirin ☐ Barbiturates ☐ Codeine ☐ Iodine ☐ Penicillin
☐ Latex ☐ Local Anesthetic ☐ Sulfa ☐ Metal Sensitivity ☐ Nitrous Oxide ☐ Other ____________________

PLEASE INDICATE Y OR N TO EACH CONDITION:

Y N	Y N	Y N	Y N
☐ ☐ Acid Reflux	☐ ☐ Bulimia	☐ ☐ Hearing Problem	☐ ☐ Psychiatric Tx
☐ ☐ ADHD	☐ ☐ Cancer/Malignancy	☐ ☐ Heart Attack	☐ ☐ Radiation/Chemo
☐ ☐ AIDS/HIV	☐ ☐ Cerebral Palsy	☐ ☐ Heart Disease	☐ ☐ Respiratory Disease
☐ ☐ Anemia	☐ ☐ Chemical Depend	☐ ☐ Heart Murmur	☐ ☐ Rheumatic Fever
☐ ☐ Anorexia	☐ ☐ Chicken Pox	☐ ☐ Hepatitis	☐ ☐ Sinus Problems
☐ ☐ Anxiety	☐ ☐ Convulsions	☐ ☐ High Blood Press	☐ ☐ Stroke
☐ ☐ Artificial Heart Valve	☐ ☐ Depression	☐ ☐ HPV	☐ ☐ Thyroid Condition
☐ ☐ Artificial Joints	☐ ☐ Diabetes	☐ ☐ Kidney Disease	☐ ☐ Tuberculosis
☐ ☐ Arthritis	☐ ☐ Dizziness/Fainting	☐ ☐ Liver Problems	☐ ☐ Ulcers
☐ ☐ Asthma	☐ ☐ Epilepsy/Seizures	☐ ☐ Mitral Valve Prolapse	☐ ☐ Venereal Disease
☐ ☐ Autism/Aspergers	☐ ☐ Freq Ear Infect	☐ ☐ Pacemaker	☐ ☐ Other:
☐ ☐ Bleeding Disorder	☐ ☐ Freq Headaches	☐ ☐ Osteoporosis	________________________

FEMALE PATIENTS: Y N Currently nursing? Y N Currently pregnant? Y N Taking birth control?

Is there anything important about your medical condition we have not asked? ☐ Yes ☐ No
If yes, please describe: ____

Have you ever taken Bisphosphonate Medications? (Ex: Actonal, Boniva, Reclast, Fosamax) ☐ Yes ☐ No

Y N Under a physician's care now? ____

Y N Any serious illnesses/surgeries/hospitalization in past 5 years?____
____

Y N Is Pre-Medication required before dental visits? If so, please specify ____

MEDICATIONS: List <u>all</u> medications you are currently taking, including dosage and diagnosis.

DRUG NAME	DOSAGE	REASON PRESCRIBED

PATIENT CONSENT: To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status, or if my medication changes, I shall inform the dentist and staff at the next appointment.

Signature ____ Date ______________________________

Relationship to patient: ☐ Adult Patient ☐ Parent ☐ Guardian ☐ Other