

PATIENT INFORMATION (Confidential)

Patient's Last Name _____ Patient's First Name _____ Preferred Name _____ M.I. _____

Social Security # _____ Home Address _____ City, State _____ Zip Code _____

Birthdate _____ Home Phone Number _____ Cell Phone Number _____ Email Address _____

Marital Status: Minor Single Separated Married Divorced Widowed Gender: _____

If Student, Name of College/University _____ College/University City, State _____ Full/Part Time Student _____

Responsible Party for Account, IF NOT PATIENT _____ Relationship to Patient _____ Social Security # _____

Responsible Party's Address _____ Home Phone Number _____ Cell Phone Number _____

Responsible Party's Email Address _____ Birthdate _____ Occupation/Employer _____ Work Phone Number _____

Emergency Contact Name _____ Relationship to Patient _____ Phone Number _____

Do you want to give us permission to speak to anyone else about your treatment or bill? Yes No

If yes, please specify who: _____

How did you hear about us? PDA Patient: _____ PDA Employee: _____

Social Media: _____ Family/Friends: _____

Referral: _____ Community Events: _____ Other: _____

Name of Previous Dentist / Location _____ Last Exam Date _____

Have you had or are experiencing any of the following:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding while brushing or flossing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent headaches |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Teeth sensitivity to hot/cold liquids or foods | <input type="checkbox"/> Yes <input type="checkbox"/> No | Clench or grind your teeth |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Teeth sensitivity to sweet/sour liquids or foods | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bite your lips or cheeks frequently |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Painful teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficult extractions |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Sores or lumps in or near your mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prolonged bleeding following extractions |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Head, neck or jaw injuries | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthodontic treatment (braces, retainers) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Clicking in your jaw | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dentures or partials |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain (join, ear, side of face) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Specific oral hygiene instruction |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty in opening or closing your mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous about dental treatment |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty in chewing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you like your smile? |

MEDICAL HISTORY

Patient Name _____ Birthdate _____

Physician _____ Office Phone Number _____ Last Exam Date _____

 1) Any concerns that you would like to discuss with the dentist? _____
 2) Are you undergoing medical treatment? Yes No
 If yes, please explain: _____

 3) Have you been hospitalized for any surgical operations or serious illness? Yes No
 If yes, please explain, including the surgery names and dates: _____

 4) Are you taking any medications, including any non-prescription medications? Yes No
 If yes, please list below.

DRUG	DOSE	FREQUENCY	REASON

 5) Have you ever taken Fen-Phen/Redux? Yes No
 6) Have you ever taken Fosamax, Boniva, Actonel, or any medications containing bisphosphonates? Yes No
 7) Have you ever had a joint replacement? Yes No
 If yes, what _____ and when _____

 8) Have you ever been told by your doctor to take antibiotics prior to dental work? Yes No

 9) Do you use tobacco in any form? Yes No
 If yes, please explain: _____

 10) Do you use recreational drugs? Yes No
 Smoking **Vaping** **Smokeless Tobacco** **Other**

If other, please list: _____

 11) Are you wearing contact lenses? Yes No

 12) Are you allergic to or have had any reactions to the following? Yes No
 Local Anesthetics Yes No
 Barbiturates Yes No
 Iodine Yes No
 Any Metals (nickel, mercury, etc.) Yes No
 Latex Yes No
 Sedatives Yes No
 Aspirin Yes No
 Penicillin Yes No
 Other Antibiotics Yes No If yes, please list: _____
 Food Yes No If yes to food, please list: _____
 Other Yes No If yes to other, please list: _____

 13) Do you have a persistent cough or throat clearing not associated with a known illness lasting over 3 weeks? Yes No

 14) Women Only:
 a. Are you pregnant or think you may be pregnant? Yes No
 b. Are you nursing? Yes No
 c. Are you taking oral contraceptives? Yes No

MEDICAL HISTORY

Patient Name _____ Birthdate _____

15) Have you had or ever been diagnosed with any of the following conditions? Please check **yes** or **no**.

- | | | |
|--|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No Sexually Transmitted Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Troubles/Ulcers |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding/Blood Clotting | <input type="checkbox"/> Yes <input type="checkbox"/> No Easily Winded |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Bone/Joint Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No Hay Fever/Allergies |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequently Tired | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Therapy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No Recent Weight Loss |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Swollen Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No Respiratory Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Replacement/Implant | <input type="checkbox"/> Yes <input type="checkbox"/> No Other _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis/Jaundice | |

Additional Comments

Authorization and Release: I certify that I have read and understand this information to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in medical status. I hereby give permission to PDA Dental Group to provide dental treatment to me and/or my child, which the doctor deems necessary and appropriate. Routine treatment may include, but not limited to, cleanings, exams, topical and local anesthetics (injections), fillings, radiographs, etc.

Responsible Party's Signature _____ **Date** _____