Hillcrest Dental, P.C.

Dr. Patrick Brannon & Dr. George Thomas

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important in providing care to you.

Today's Date:_____

Patient's name_____Preferred name_____ Birth date_____

If minor, parent/guardian_____Gender_____

E-mail address_____Social Security #_____

Cell_____Home_____Work_____Primary contact # (circle one) Cell/Home/Work

Mailing address_____City_____State_____Zip_____

Employer_____Occupation_____

Whom may we thank for referring you to our office? _____

Emergency Contact Name_____Primary contact #_____

DENTAL HEALTH HISTORY

Please check any that apply:

- ☐ Satisfied with appearance of your teeth
- ☐ Apprehensive about dental treatment
- ☐ Gag easily
- ☐ Wear dentures or partials
- ☐ Food catches between teeth
- ☐ Difficulty chewing food
- ☐ Avoid brushing areas of mouth because of pain
- ☐ Tooth sensitivity
- ☐ Do you feel pain when your teeth come into contact with:
  - o Hot foods or liquids
  - o Cold foods or liquids
  - o Sour
  - o Sweet
- ☐ Gums bleed easily
- ☐ Gums bleed when you floss
- ☐ Gums feel swollen or tender
- ☐ Dry mouth
- ☐ Snore
- ☐ Take fluoride supplements
- ☐ Jaw related issues:
  - o Jaw pain or discomfort
  - o Popping/clicking noises
  - o Clench and/or grind
  - o Limited opening or movement
  - o Jaw feel tired
  - o Jaw gets stuck or locked
  - o Jaw tenderness or headaches in the morning

Last dental appointment?_____

What was it for?_____

Purpose of today's visit?_____

How often do you brush?_____

How often do you floss?_____

MEDICAL HEALTH HISTORY

Do you have any of the following?
(Please check any that apply)

- ☐ Cancer. Type_____
- ☐ Heart disease or angina
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Artificial joint, heart valve or stent. Surgery date_____
- ☐ High or low blood pressure (circle one)
- ☐ Pacemaker
- ☐ Tuberculosis or other lung problems
- ☐ Kidney disease
- ☐ Hepatitis or other liver disease
- ☐ Alcoholism or drug abuse
- ☐ Blood transfusion
- ☐ Diabetes
- ☐ Neurologic condition
- ☐ Epilepsy, seizures, or fainting spells
- ☐ Mental Health issues
- ☐ Arthritis
- ☐ Herpes or cold sores
- ☐ AIDS or HIV positive
- ☐ Migraine headaches
- ☐ Anemia or blood disorders
- ☐ Abnormal bleeding after extractions, surgery, or trauma
- ☐ Hay fever or sinus trouble
- ☐ Allergies or hives
- ☐ Asthma
- ☐ Hypo or hyper thyroidism (circle one)

Do you/have you use(d) tobacco? ☐ Yes ☐ No
Any hospitalizations or surgeries in the past five years? ☐ Yes ☐ No

Are you allergic to, or have you reacted to any of the following?

- ☐ Latex materials
- ☐ Penicillin or other antibiotics
- ☐ Dental local anesthetics
- ☐ Codeine or other narcotics
- ☐ Sulfa drugs
- ☐ Aspirin, Ibuprofen, or other NSAIDS
- ☐ Metals or Acrylics
- ☐ Other:_____

Are you taking any of the following?

- ☐ Aspirin
- ☐ Anticoagulants (blood thinners)
- ☐ Antibiotics or sulfa drugs
- ☐ High blood pressure medicine
- ☐ Antidepressants or tranquilizers
- ☐ Insulin or other diabetes drug
- ☐ Cortisone or other steroids
- ☐ Osteoporosis (bone density) medicine
- ☐ Other:_____

Women:

- ☐ May be pregnant
- ☐ Taking hormones or contraceptives
- ☐ Are you nursing?

List of Medications: _____

_____

Name of your physician: _____

Do you have any disease, condition, or problem not listed above? _____

Any additional information about your medical history: _____

_____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible for any action they take or do not take because of errors/omissions that I may have made in the completion of this form.

Signature of patient (or parent/guardian) _____Date_____

Signature of reviewing dentist_____Date_____

Reviewing Dentist notes: _____

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