COAST DENTAL

PATIENT'S DENTAL HEALTH

Account Number ______________

Patient Name	Previous Dentist Name	
Reason For Changing Dentists	Last Visit	Last Cleaning

Have you had any problems with past dental treatment?

Are you nervous about seeing a dentist?
☐ Yes ☐ No If yes, please tell us why

How often do you brush?

Do you floss?
☐ Yes ☐ No How Often?

Please circle Y for YES and N for NO

Y N I clench or grind my teeth during teh day or while sleeping
Y N My gums bleed while brushing or flossing
Y N I like my smile
Y N I prefer tooth colored fillings
Y N I avoid brushing part of my mouth due to pain
Y N My gums feel tender or swollen
Y N I have problems eating
Y N I have had orthodontics
Y N I want my teeth straighter
Y N I want my teeth whiter

What are your dental priorities? (appearance, dental health, financial considerations) ______________________________

PATIENT'S MEDICAL HISTORY

I consider my health to be (Please check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have or had any of the following? Please circle

Y N Heart Disease
Y N Heart Murmur/Mitral Valve Prolapse
Y N Stroke
Y N Congenital Heart Lesions
Y N Rheumatic Fever
Y N Abnormal Blood Pressure
Y N Anemia
Y N Prolonged Bleeding Disorder
Y N Tuberculosis or Lung Disease
Y N Asthma
Y N Hay Fever
Y N Sinus Trouble
Y N Liver Disease
Y N Jaundice
Y N Hepatitis Type ____________
Y N Diabetes
Y N Excessive Urination and/or Thirst
Y N Infectious Mononucleosis "Mono"
Y N Herpes
Y N Arthritis
Y N Sexually Transmitted/Venereal Diseases
Y N Kidney Disease
Y N Tumor or Malignancy
Y N Cancer/Chemotherapy
Y N AIDS
Y N Immune Supressed Disorder
Y N Hearing Loss
Y N Fainting Spells
Y N Glaucoma
Y N History of Emotional Nervous Disorder
Y N History of Drug Addiction
Y N Radiation Therapy
Y N Ulcers
Y N Epilepsy/Seizures

Y N Implants/Artificial Joins/Hip-Knee/Other __________________________
Y N I smoke or use chewing tobacco. If yes, how much per day? ______________ Years? _______
Y N I have consumed alcohol within the last 24 hours
Y N I usually take an antibiotic prior to dental treatment
Y N Have you ever taken Fen-Phen or Redux?
Y N I have had major surgery. Year ________ Type of Operation__________________________

WOMEN

Y N Are you taking birth control?
Y N Are you or could you be pregnant?

Y N Do you have any other medical problems or medical history NOT listed on this form?______________________________

Are you allergic to any of the following? Please circle

Y N Aspirin
Y N Sulfa Drugs/Sulfites/Sulfides
Y N Penicillin
Y N Codeine
Y N Latex, Metals, Plastics
Y N Local Anesthetics (Novacaine)
Y N Other Medications ________________

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING

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EMERGENCY CONTACT INFORMATION

In case of emergency, please contact (list 2 contacts)

Name __________________ Relationship ______________ Phone ____________ Alternate Phone ____________

Name __________________ Relationship ______________ Phone ____________ Alternate Phone ____________

Medical Health Reviewed By:

Doctor's Signature ______________________ Date ___________

Patient/Parent or
Gaurdian Signature ______________________ Date ___________