Welcome

ADKINS DENTISTRY — DDS, PLLC —

About You

Date of Birth: _____ Today's Date: _____

Name: _____ I like to be called: _____

Mailing address: _____

Physical address: _____

Please check preferred contact:

❑ Home Phone: _____ ❑ Work Phone: _____ ❑ Cell Phone: _____

E-mail: _____

Social Security Number (required): _____

Driver's License (required): _____

Employer: _____ Occupation: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Spouse's name: _____

In case of an emergency, is there someone we can call?

Name: _____

Phone Number: _____

How did you hear about us? _____

_____

Dental History

Why have you come to see us today? _____

How would you describe the condition of your teeth and gums?

❑ Good ❑ Fair ❑ Poor

❑ Are you currently in pain or discomfort with your teeth and gums?

If yes, please explain: _____

_____

The date of your last dental visit: _____ Previous dentist's name: _____

How often do you brush your teeth? _____ Floss your teeth? _____

❑ Do your gums bleed when you brush? ❑ Floss?

❑ Have you ever experienced pain in your jaw point? ❑ Do you grind your teeth?

❑ Have you ever been treated for TMJ symptoms?

If yes, Please explain: _____

If you could easily and safely whiten your teeth, would you be interested? _____

Health History

❑ Have you been hospitalized in the last 5 years?
If yes, reason: _____

❑ Are you currently receiving care?
If yes, nature of care:_____

Date of last health care exam:_____

What was this exam for?_____

What pharmacy do you use? _____

Please list all the names and phone numbers of the physicians who are currently providing you care along with the date of your last visit.

1. _____

2. _____

For the following questions please check all that apply. Your answers are for our records and will be confidential. Please note that during your initial visit you will be asked some questions about your responses. Our team may ask additional questions concerning your health.

- ❑ Heart murmur (mitral valve prolapse)
- ❑ Anemia
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Hepatitis, any form
- ❑ Rheumatic fever
- ❑ Asthma
- ❑ HIV positive or AIDS related complications
- ❑ Emphysema or other respiratory illnesses
- ❑ Abnormal heart condition
- ❑ Kidney disease
- ❑ Heart (surgery, disease, attack)
- ❑ Venereal disease (Syphilis, Chlamydia, Herpes, etc.)
- ❑ Blood Thinners
- ❑ History of alcohol or substance misuse/abuse?
- ❑ Recreational drug use
- ❑ Psychosis
- ❑ Sore/enlarge lymph nodes
- ❑ Previous biopsies
- ❑ Slow-healing mouth sores
- ❑ Other infections
- ❑ Recurrent Illnesses
- ❑ Are you allergic or have you had a reaction to:
  - ❑ Local anesthetic
  - ❑ Penicillin or other antibiotics
  - ❑ Aspirin
  - ❑ Vitamins and supplements
  - ❑ Codeine, Valium or other sedatives
  - ❑ Latex
  - ❑ Other_____
- ❑ Are you a smoker?
  - ❑ If yes, how much do you smoke per day?_____
- ❑ Women:
  - ❑ Are you taking birth control pills?
  - ❑ Are you pregnant?
  - ❑ If no, are you planning a pregnancy in the near future?
  - ❑ Are you a nursing mother?
- ❑ Other_____

Please list any medications you are currently taking:

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

I understand that the information is correct to the best of my knowledge. I understand it will be held in the strictest confidence an only be used to improve communication between the doctor and myself. I also give permission for the doctor or his staff to use any photos they may take to be used for lecturing or education purposes.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE_____