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? ________________________________

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

Have you been treated previously for gum disease? ________________________

Do you clench or grind your teeth? ❑ Yes ❑ No

Have you ever had an adverse response to any dental treatment? ________________

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

❑ Good ❑ Fair ❑ Poor

Are you satisfied with the appearance of your teeth and smile?

Please explain: ____

____

Are you currently experiencing pain or discomfort with your teeth or gums?

Please explain: ____

____

Health History

Please list the names and phone numbers of physicians currently providing you care:

____

____

Have you had a medical exam in the past 12 months? ______________________

Have you been hospitalized in the past 5 years? ______________________

For the following questions please check all that apply. Your answers allow us to better serve you and safely provide dental treatment and will be confidential. Our team may ask additional questions to best understand your unique concerns.

- ❑ High Blood Pressure
- ❑ Angina Pectoris
- ❑ Heart Attack(s)
- ❑ Rheumatic Fever
- ❑ Heart Disease
- ❑ Artificial Heart Valve
- ❑ Arrhythmias/Pacemaker
- ❑ Anemia
- ❑ Hemophilia or Bleeding Disorders
- ❑ Blood Thinners
- ❑ Blood Transfusion
- ❑ Leukemia
- ❑ HIV Positive
- ❑ Stroke
- ❑ Epilepsy, Seizure, Convulsions
- ❑ Stomach or Intestinal Concerns
- ❑ Acid Reflux/GERD
- ❑ Hepatitis, Cirrhosis, Liver Disease
- ❑ Asthma
- ❑ Emphysema/Chronic Bronchitis
- ❑ Shingles/Herpes/Cold Sores
- ❑ Anxiety/Phobias
- ❑ Tuberculosis
- ❑ Sleep Apnea / Snoring
- ❑ Arthritis
- ❑ Prosthetic Joints
- ❑ Diabetes
- ❑ Thyroid Concerns
- ❑ Renal (Kidney) Disease
- ❑ Venereal Disease
- ❑ Tobacco and/or Alcohol Use
- ❑ History of Substance Misuse/Abuse
- ❑ Tumors and/or Cancer
- ❑ Radiation Therapy and Chemotherapy
- ❑ Steroid Therapy
- ❑ Previous Operations or Hospitalizations
- ❑ 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?

Please list all know allergies and contraindicated medications: ______________________

____

Please list all medications you are currently taking. You may provide separate list if more convenient.

____

____

____

____

Do you have any health related concerns not specifically addressed on this form? ______________________

I understand that the information is correct to the best of my knowledge. I understand it will be held in the strictest confidence and only be used to improve communication between the doctor and myself.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN ______________________ DATE ____________