SAUTTER FAMILY DENTISTRY

Patient Information

Patient Name: _____ Date:____/____/_____
First Last
Preferred Name:_____ Date of Birth:_____/_____/_____ Gender: ☐ Male ☐ Female

Social Security #_____-_____-_____ Parent/Guardian (if under 18):_____

Address:_____
Street Ste/Apt # City Sate Zip Code
Phone (Home): (_____)_____ (Work): (_____)_____ (Cell): (_____)_____

Best method of contact (cell/email):_____ Email:_____

Reason for this visit:_____

Dental History

	Yes	No	Maybe
Date of last dental exam and xrays:_____/_____/_____			
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Do your gums bleed when you brush or floss?	☐	☐	☐
Have you had Periodontal (gum) treatments before?	☐	☐	☐
Have you had any ***dental*** problems associated with previous dental treatment?	☐	☐	☐

How do you feel about your smile?_____

Medical Information

Medical Physician's Name:_____ Phone: (_____)_____

Do you have or have you ever had any of the following? ***Please check all that apply***

- ☐ Abnormal bleeding
- ☐ Acid Reflux/ Heartburn
- ☐ Alcohol Abuse
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Bones/Joints
- ☐ Artificial heart valve
- ☐ Asthma
- ☐ Blood transfusion
- Date:_____
- ☐ Cancer/Chemotherapy
- ☐ Cholesterol (high)
- ☐ Congenital Heart Defect
- ☐ Diabetes ***I or II***
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting Spells
- ☐ Fever Blister
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis ***A B or C***
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Psychiatric Problems
- ☐ Radiation treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Severe Headaches/Migraines
- ☐ Thyroid Problems
- ☐ Respiratory Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Women Only: ***Are you currently…***
Taking Birth Control Pills? ☐ Yes ☐ No
Pregnant? ☐ Yes ☐ No
if so, what week?_____
Nursing? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No
(cigarettes, cigars, chew)

If so, how interested are you in quitting? (circle one)
VERY SOMEWHAT NOT INTERESTED

- Have you ever had ***medical*** complications following dental treatment? ☐ Yes ☐ No

If Yes, Please Explain _____

- Do you have any other health problems that need further clarification? ☐ Yes ☐ No

If Yes, Please Explain _____

Are you allergic to (circle): ***Penicillin*** ***Latex*** ***Codeine/Narcotics*** ***Sulfa Drugs***
Please list any other allergies:_____
Please list all medications you are currently taking: _____
_____
Has a Physician or previous Dentist required that you take antibiotics prior to dental treatment? ☐ Yes ☐ No

Signature of Patient/Legal Guardian_____ Date:_____/_____/_____

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. 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 the staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. If I ever have any changes in my health, I will inform the doctors at the next appointment. I will not hold my dentist, or any other member of the staff, responsible for any action they take or do not take because of errors or omissions that I may have made in completion of this form.