FRONT ROYAL DENTAL CARE

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GENERAL INFORMATION

Title: _____ First Name: _____ MI: _____ Last Name: _____

Preferred Name: _____ Gender: ❑ Male ❑ Female Married: ❑ Yes ❑ No

Home: _____ Work: _____ Cell: _____ Can we text you? ❑ Yes ❑ No

Email Address: _____ DOB: _____ SS#:_____

Email opt in: *I authorize Front Royal Dental Care to send emails that may contain protected health information such as treatment information, appointment times, etc. as requested by me to the email address listed above.* ❑ Yes ❑ No

Preferred Contact Method: ❑ Work Phone ❑ Home Phone ❑ Cell Phone ❑ Text ❑ Email ❑ Mail

Address: _____ City: _____ State: _____ Zip: _____

Is address same for the entire family? ❑ Yes ❑ No

Emergency Contact: _____ Relationship: _____ Ph#_____

FINANCIAL INFORMATION

❑ **Dental Insurance** ❑ **No Insurance** ❑ **Front Royal Dental Care Membership Plan** ❑ **Care Credit**

Dental Insurance:

Subscriber's Full Name: _____ Relationship to subscriber: ❑ Self ❑ Spouse ❑ Child

Subscriber's Employer: _____ Insurance Company: _____

Group number: _____ Subscriber ID: _____

Subscriber's DOB: ____/____/_____ Subscriber's SS#:_____ Phone # on back of Card: _____

Responsible Party if not Patient:

First Name: _____ MI: _____ Last Name: _____

Address: _____ Phone Number: _____

How did you hear about our office? Please mark all that apply.

❑ Drive/Walk by ❑ Facebook ❑ Referral _____

❑ Google search ❑ Yelp ❑ Other _____

❑ Insurance Company ❑ Community Event

DENTAL HISTORY

Last Name: _____ **First Name:** _____ **DOB:** ____/____/_____

Why are you changing dentists?

❑ Change of residence ❑ Your office is closer ❑ Unhappy ❑ You were recommended
❑ Change of dental plan ❑ My dentist retired/closed ❑ Too Expensive ❑ Other

Please explain:

How long since your last visit to dentist?

❑ 1-5 months ❑ 1-3 years ❑ Never
❑ 6-12 months ❑ 4+ Years

Reason for you visit? ❑ Check-up ❑ Cleaning ❑ Pain ❑ Other

Please explain:

Have you ever had a bad experience at the dentist? ❑ Yes ❑ No

If yes please explain:

Have you ever had complications following dental treatment? ❑ Yes ❑ No

If yes please explain:

Dental Health Questions

❑ Y ❑ N Are you experiencing any discomfort?
❑ Y ❑ N Do you snore?
❑ Y ❑ N Do you have bleeding gums?
❑ Y ❑ N Do you have bad breath?
❑ Y ❑ N Do you grind or clinch your teeth?
❑ Y ❑ N Do you play sports?
❑ Y ❑ N Do you have dry mouth?
❑ Y ❑ N Are you sensitive to ❑ hot, ❑ cold or ❑ sweets?

❑ Y ❑ N Have you ever received Periodontal (Gum) Therapy?
❑ Y ❑ N Do you use a fluoride supplement?
❑ Y ❑ N Do you use tobacco?
❑ Y ❑ N Do you drink coffee or tea?
❑ Y ❑ N Are you interested in having whiter/brighter teeth?
❑ Y ❑ N Do you have difficulty brushing your teeth?
❑ Y ❑ N Do you have difficulty flossing your teeth?

How would you rate your smile on a scale from 1 to 10, with 10 being the highest? 1 2 3 4 5 6 7 8 9 10

What would you change about your smile if you could? _____

Denture/Partial Patients

❑ Y ❑ N Do you wear a denture or partial? How old is your denture or partial? _____
❑ Y ❑ N Does your denture or partial cause irritation?
❑ Y ❑ N Are your dentures loose?

MEDICAL HISTORY

Last Name: _____ **First Name:** _____ **DOB:** ____/____/_____

Primary Care Physician: _____ **Physician's Phone:** _____

- ❑ Y ❑ N Are you under a physician's care?
- ❑ Y ❑ N Have you ever had a serious head or neck injury?
- ❑ Y ❑ N Have you been admitted to hospital in last 2 years?
- ❑ Y ❑ N Are you pregnant, trying to get pregnant or nursing?
- ❑ Y ❑ N Have you ever taken medications for osteoporosis?

If you answered yes to any of the above questions, please explain:

Are you allergic or do you react adversely to any of the following?

- ❑ Y ❑ N Asprin
- ❑ Y ❑ N Acrylic
- ❑ Y ❑ N Sulfa drugs
- ❑ Y ❑ N Penicillin or other antibiotics

Which ones? _____

- ❑ Y ❑ N Tetracycline
- ❑ Y ❑ N Metal
- ❑ Y ❑ N Codeine
- ❑ Y ❑ N Barbiturates, sedatives or Sleeping Pills

- ❑ Y ❑ N Latex
- ❑ Y ❑ N Local anesthetics (Novacaine-like medication)
- ❑ Y ❑ N Milk Protein

Please check any conditions that you currently or previously have had:

- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve
- ❑ Artificial Joint
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problems
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Emphysema
- ❑ Endocarditis
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Excessive thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack/Failure
- ❑ Heart Murmur
- ❑ Heart Pacemaker
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Leukemia
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse
- ❑ Osteoporosis
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Parkinson's Disease
- ❑ Pins, Rods, Stints or Shunts
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problem
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice
- ❑ None

Please list any other conditions you have had or currently have:

MEDICAL HISTORY *(cont.)*

Last Name: _____ **First Name:** _____ **DOB:** ____/____/_____

Please check any medications and/or supplements taken in the past 12 months:

- ❑ Antibiotics or sulfa drug
- ❑ Tranquilizer
- ❑ Anticoagulants (e.g. Coumadin, blood thinners)
- ❑ Aspirin (daily)
- ❑ Contraceptives
- ❑ Heart medications
- ❑ Radiation / Chemotherapy
- ❑ Insulin or diabetes medication
- ❑ Bisphosphonates (used to treat osteoporosis, such as Fosamax, Boniva, Actonel and Zometa)
- ❑ Herbal supplements
- ❑ Phen-Fen or Redux
- ❑ High blood pressure medication
- ❑ Nitroglycerin *(Please bring with you)*
- ❑ Inhaler/Asthma/COPD *(Please bring with you)*

List all medications/supplements you are currently taking:

I have answered all questions to the best of my knowledge. I will notify Front Royal Dental Care of any change in my health or medication at each visit.

I authorize Front Royal Dental Care to use the necessary local/topical anesthetic to perform my treatment in a safe, effective manner, during this visit and any future visits. I understand that my failure to provide information on previous adverse reactions may cause unforeseen negative reactions. I release Front Royal Dental Care of all liability regarding undisclosed medical history information.

_____ _____ _____

Print Name of Client or Guardian **Date** **If authorized guardian, relationship to client**

_____ _____

Signature of Client or Guardian **Date**

(If filling out online signature will be captured later)