**Hillcrest Dental, P.C.**

Dr. Patrick Brannon & Dr. George Thomas

**PATIENT INFORMATION**

*Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important in providing care to you.*

**Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date\_\_\_\_\_\_\_\_\_\_\_\_\_

 If minor, parent/guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary contact # (circle one) Cell/Home/Work

Mailing address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary contact #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HEALTH HISTORY**

 Please check any that apply:

* Gums bleed easily
* Gums bleed when you floss
* Gums feel swollen or tender
* Dry mouth
* Snore
* Take fluoride supplements
* Jaw related issues:
	+ Jaw pain or discomfort
	+ Popping/clicking noises
	+ Clench and/or grind
	+ Limited opening or movement
	+ Jaw feel tired
	+ Jaw gets stuck or locked
	+ Jaw tenderness or headaches in the

morning

* Satisfied with appearance of your teeth
* Apprehensive about dental treatment
* Gag easily
* Wear dentures or partials
* Food catches between teeth
* Difficulty chewing food
* Avoid brushing areas of mouth because of pain
* Tooth sensitivity
* Do you feel pain when your teeth come into

contact with:

* + Hot foods or liquids
	+ Cold foods or liquids
	+ Sour
	+ Sweet

 Last dental appointment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was it for?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of today’s visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you brush?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you floss?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Revised April 2017**

**MEDICAL HEALTH HISTORY**

Are you allergic to, or have you reacted to any of

the following?

* Latex materials
* Penicillin or other antibiotics
* Dental local anesthetics
* Codeine or other narcotics
* Sulfa drugs
* Aspirin, Ibuprofen, or other NSAIDS
* Metals or Acrylics
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any of the following?

* Aspirin
* Anticoagulants (blood thinners)
* Antibiotics or sulfa drugs
* High blood pressure medicine
* Antidepressants or tranquilizers
* Insulin or other diabetes drug
* Cortisone or other steroids
* Osteoporosis (bone density) medicine
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women:

* May be pregnant
* Taking hormones or contraceptives
* Are you nursing?

Do you have any of the following?

(Please check any that apply)

* Cancer. Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Heart disease or angina
* Heart murmur, mitral valve prolapse, heart defect
* Rheumatic fever or rheumatic heart disease
* Artificial joint, heart valve or stent. Surgery date\_\_\_\_\_\_\_\_\_\_
* High or low blood pressure (circle one)
* Pacemaker
* Tuberculosis or other lung problems
* Kidney disease
* Hepatitis or other liver disease
* Alcoholism or drug abuse
* Blood transfusion
* Diabetes
* Neurologic condition
* Epilepsy, seizures, or fainting spells
* Mental Health issues
* Arthritis
* Herpes or cold sores
* AIDS or HIV positive
* Migraine headaches
* Anemia or blood disorders
* Abnormal bleeding after extractions, surgery, or trauma
* Hay fever or sinus trouble
* Allergies or hives
* Asthma
* Hypo or hyper thyroidism (circle one)

Do you/have you use(d) tobacco? 🞎 Yes 🞎 No

Any hospitalizations or surgeries in the past five years? 🞎 Yes 🞎 No

List of Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of your physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any disease, condition, or problem not listed above? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any additional information about your medical history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible for any action they take or do not take because of errors/omissions that I may have made in the completion of this form.

Signature of patient (or parent/guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of reviewing dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewing Dentist notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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