

## Welcome to Above the Gate Dentistry!



Name: \_\_\_\_\_ DOB: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

What is your preferred method of contact? \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

SSN: \_\_\_\_\_ Driver's Lic #: \_\_\_\_\_ Emerg. Contact: \_\_\_\_\_

Emerg. contact #: \_\_\_\_\_

**Are you the responsible party? \_\_\_\_ Yes \_\_\_\_ No**

**If not, please enter the information below:**

Responsible Party Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ SSN: \_\_\_\_\_ Driver's Lic. # \_\_\_\_\_

**Do you have Dental Insurance? \_\_\_\_ Yes \_\_\_\_ No**

**If so, please fill out the information below:**

Policy Holder Name: \_\_\_\_\_ Policy Holder SSN/ID: \_\_\_\_\_

DOB: \_\_\_\_\_ Employer Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

**If you are covered under a secondary insurance, please fill out below:**

Policy Holder Name: \_\_\_\_\_ Policy Holder SSN/ID: \_\_\_\_\_

DOB: \_\_\_\_\_ Employer Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

**\*\*As a service to you, we strive to be accurate in our estimations. However, these are only estimations. Ultimately you are responsible for the total balance owed to our office. Thank you! \*\***

Initial here that you have read and understand the above: \_\_\_\_\_

# Medical History

Patient Name: \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your entire body health is extremely important to all treatment. Health problems you may have or medication you may be taking could have an important interrelationship with the dentistry you receive. Thank you!

Are you under a physician's care now? Yes \_\_\_ No \_\_\_ If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation? Yes \_\_\_ No \_\_\_ If yes, please explain: \_\_\_\_\_

Have you have any major neck/head injury? Yes \_\_\_ No \_\_\_ If yes, please explain: \_\_\_\_\_

Are you currently taking any medications? Yes \_\_\_ No \_\_\_ If yes, please explain: \_\_\_\_\_

Are you on a special diet? Yes \_\_\_ No \_\_\_ \_\_\_\_\_

Do you use tobacco? Yes \_\_\_ No \_\_\_ \_\_\_\_\_

Do you used controlled substances? Yes \_\_\_ No \_\_\_ \_\_\_\_\_

Do you need a pre-med before dental appointments? Yes \_\_\_ No \_\_\_ If yes, please explain \_\_\_\_\_

Please mark any of the following that you are allergic to:

\_\_\_\_\_ Tetracycline \_\_\_\_\_ Penicillin \_\_\_\_\_ Codeine \_\_\_\_\_ Acrylic \_\_\_\_\_ Latex \_\_\_\_\_ Metal \_\_\_\_\_ Local Anes.  
 Other (Please explain): \_\_\_\_\_

**For Women:**

Are you pregnant/Trying to get pregnant? Yes \_\_\_ No \_\_\_ Taking oral contraceptives? Yes \_\_\_ No \_\_\_ Nursing? Yes \_\_\_ No \_\_\_

**Do you have, or have you had any of the following? (Please be sure to mark either "yes" or "no")**

AIDS/HIV Positive	Yes ___ No ___	Excessive Bleeding	Yes ___ No ___	Lung Disease	Yes ___ No ___
Alzheimer's Disease	Yes ___ No ___	Excessive Thirst	Yes ___ No ___	Mitral Valve Prolapse	Yes ___ No ___
Anaphylaxis	Yes ___ No ___	Fainting Spells/Dizziness	Yes ___ No ___	Pain in Jaw Joints	Yes ___ No ___
Anemia	Yes ___ No ___	Frequent Cough	Yes ___ No ___	Parathyroid Disease	Yes ___ No ___
Angina	Yes ___ No ___	Frequent Diarrhea	Yes ___ No ___	Psychiatric Care	Yes ___ No ___
Arthritis/Gout	Yes ___ No ___	Genital Herpes	Yes ___ No ___	Radiation Treatments	Yes ___ No ___
Artificial Heart	Yes ___ No ___	Glaucoma	Yes ___ No ___	Recent Weight Loss	Yes ___ No ___
Artificial Joint	Yes ___ No ___	Hay Fever	Yes ___ No ___	Renal Dialysis	Yes ___ No ___
Asthma	Yes ___ No ___	Heart Attack/Failure	Yes ___ No ___	Rheumatic Fever	Yes ___ No ___
Blood Disease	Yes ___ No ___	Heart Murmur	Yes ___ No ___	Rheumatism	Yes ___ No ___
Blood Transfusion	Yes ___ No ___	Heart Pacemaker	Yes ___ No ___	Scarlet Fever	Yes ___ No ___
Breathing Problem	Yes ___ No ___	Heart Trouble/Disease	Yes ___ No ___	Shingles	Yes ___ No ___
Bruise Easily	Yes ___ No ___	Hemophilia	Yes ___ No ___	Sickle Cell Disease	Yes ___ No ___
Cancer	Yes ___ No ___	Hepatitis A	Yes ___ No ___	Sinus Trouble	Yes ___ No ___
Cataracts/Replacement	Yes ___ No ___	Hepatitis B or C	Yes ___ No ___	Spina Bifida	Yes ___ No ___
Chemotherapy	Yes ___ No ___	Other Hepatitis (___)	Yes ___ No ___	Stomach Disease	Yes ___ No ___
Chest Pains	Yes ___ No ___	Herpes (Oral)	Yes ___ No ___	Stroke	Yes ___ No ___
Cold Sores/Fever Blisters	Yes ___ No ___	High Blood Pressure	Yes ___ No ___	Swelling of Limbs	Yes ___ No ___
Congential Heart Disorder	Yes ___ No ___	High Chloolesterol	Yes ___ No ___	Thyroid Disease	Yes ___ No ___
Convulsions	Yes ___ No ___	Hives/Rash	Yes ___ No ___	Tonsillitis	Yes ___ No ___
Cortisone Medicine	Yes ___ No ___	Hypoglycemia	Yes ___ No ___	Tuberculosis	Yes ___ No ___
Diabetes	Yes ___ No ___	Irregular Heartbeat	Yes ___ No ___	Tumors/Growths	Yes ___ No ___
Drug Addiction	Yes ___ No ___	Kidney Problems	Yes ___ No ___	Ulcers	Yes ___ No ___
Easily Winded	Yes ___ No ___	Leukemia	Yes ___ No ___	Venereal Disease	Yes ___ No ___
Emphysema (COPD)	Yes ___ No ___	Liver Disease	Yes ___ No ___		
Epilepsy or Seizures	Yes ___ No ___	Low Blood Pressure	Yes ___ No ___		

Have you ever had any serious illness not listed above? Yes \_\_\_ No \_\_\_ If so, please explain: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status.**

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

# Dental History

Patient Name: \_\_\_\_\_

## Previous Dentist Information

Prev. Dentist Name: \_\_\_\_\_ Prev. Dentist Phone: \_\_\_\_\_

Date of Last Dental Appointment: \_\_\_\_\_ May we request records? Yes \_\_\_\_\_ No \_\_\_\_\_

May we inquire why you left your previous dentist? \_\_\_\_\_

## Family History

Please mark if you have any of the following disease history in your family:

\_\_\_\_\_ Cancer    \_\_\_\_\_ Heart Disease    \_\_\_\_\_ Diabetes    \_\_\_\_\_ Nerve Disease    \_\_\_\_\_ Nervous Disorders

## I would like the dental team to help me with the following (mark all that apply)

\_\_\_\_\_ I would like to know about early detection of potential problems and/or how I can avoid dental pain and problems.

\_\_\_\_\_ I would like to deal with only the teeth that feel pain.

\_\_\_\_\_ I am concerned about wear on my teeth.

\_\_\_\_\_ I am unable to chew the foods that would like to eat.

\_\_\_\_\_ I would like to know more about straightening my teeth or closing gaps in between my teeth.

\_\_\_\_\_ I am concerned that my teeth are getting loose.

\_\_\_\_\_ I have a painful or broken tooth or pain in my mouth other than a tooth.

\_\_\_\_\_ I have broken teeth in the past.

\_\_\_\_\_ I have been told or I suspect that I have gum disease.

\_\_\_\_\_ I would like to change the shape of my front teeth

\_\_\_\_\_ I am interested in a whiter smile.

\_\_\_\_\_ I am concerned with sensitivity, what causes this?

\_\_\_\_\_ I am concerned about having any or excessive x-rays or radiographs taken.

\_\_\_\_\_ I would like to know more about the pain management techniques this office offers (Nitrous oxide, numbing, etc.)

\_\_\_\_\_ I would like to know more about how I can replace my missing teeth and/or dental implants.

\_\_\_\_\_ Food catches between my teeth or I have areas that are difficult to floss.

\_\_\_\_\_ I have noticed spots or stains on my teeth that concern me.

\_\_\_\_\_ I think I may be experiencing dry mouth.

\_\_\_\_\_ Other (Additional dental questions/concerns) \_\_\_\_\_

What would you like our office team to know about you? \_\_\_\_\_

What would you like to know about our office? \_\_\_\_\_