**Welcome to Palm Dental, PLLC**

*Please fill out the following information, so that we can better serve you*.

**Patient Information:**

Last Name First Name

Address City State Zip

Home Phone Number Cell Phone Number Work Phone Number

Social Security Number Date of Birth E-mail

Emergency Contact Name Phone Number

**Policy Holder / Responsible Party Information**:

Name (if other than patient name) Relationship to patient

Address City State Zip

Policy Holder’s Date of Birth Social Security Number

Employer Name

Dental History

Previous Dentist Name Reason for Leaving

Date of last Cleaning / Exam

Explain the reason for your visit today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you experiencing any discomfort? …………………………. Y/N

Does dental treatment make you nervous? …………………. Y/N

Do you snore? ……………………………………………………………… Y/N

Do you have bleeding gums? ………………………………………..Y/N

Do you have bad breath? ……………………………………………….Y/N

Do you grind your teeth? ……………………………………………….Y/N

Do you use an athletic mouth guard? …………………………….Y/N

Are you sensitive to hot, cold or sweets? ……………………..Y/N

Have you ever received Periodontal Therapy? ……………..Y/N

Do you take Fluoride supplement? ………………………………..Y/N

Do you use tobacco? ……………………………………………………..Y/N

Do you drink coffee or tea? .............................................Y/N

Interested in having whiter/brighter?..............Y/N

If you could change your smile, what would you change? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have difficulty brushing your teeth? Y/N explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentures / Partial Patients:

Do you wear a denture or partial? …………………………………………………Y/N

How old is your denture or partial? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever broken or cracked them? ……………………………………….Y/N

Have your dentures/partials ever been relined? …………………………..Y/N

Does your denture/partial cause irritation or soreness? ……………….Y/N

Are your dentures loose?..................................................................Y/N

Do you use denture adhesive?..........................................................Y/N

Do you use denture cleaner?............................................................Y/N

Do you use product(s) to prevent denture odor? ………………………...Y/N

Medical History:

Primary Care Physician Name Physician Phone Number

Are you under a physician’s care? ………………………………………………………..Y/N

Have you ever been hospitalized or had a major operation? ……………….Y/N

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your physician ever advised you to take a pre-medication (antibiotics) before dental treatment?.Y/N

Have you ever had a serious head and neck injury? ...............................Y/N

Do you take, or have you taken, Phen-Fen or Redux? ………………………….Y/N

WOMEN: Are you pregnant, or trying to get pregnant or nursing? ………Y/N

If expecting, what is your due date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have tongue piercing? .................................................................Y/N

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

Aspirin…………………………..Y/N

Acrylic…………………………….Y/N

Sulfa drugs……………………..Y/N

Penicillin…………………………Y/N

Any other Antibiotics……..Y/N….if yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Barbiturates, sedatives or sleeping pills…………..Y/N

Codeine………………………….Y/N

Latex…………………………..….Y/N

Local Anesthetics……….….Y/N

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any condition that you may currently or previously have had:**

\_\_\_\_AIDS/HIV Positive \_\_\_\_Glaucoma

\_\_\_\_Alzheimer’s Disease \_\_\_\_Hay Fever

\_\_\_\_Anaphylactic Shock \_\_\_\_Heart Attack

\_\_\_\_Anemia \_\_\_\_Heart Murmur

\_\_\_\_Angina \_\_\_\_Heart Pacemaker

\_\_\_\_Arthritis/Gout \_\_\_\_Heart Trouble/Disease

\_\_\_\_Artificial Heart Valve \_\_\_\_Stroke

\_\_\_\_Asthma \_\_\_\_Mitral Valve Prolapse

\_\_\_\_Hemophilia \_\_\_\_Spina Bifida

\_\_\_\_Hepatitis A \_\_\_\_Shingles

\_\_\_\_Breathing Problem \_\_\_\_Hepatitis B or C

\_\_\_\_Bruise easily \_\_\_\_Herpes

\_\_\_\_Cancer \_\_\_\_High Blood Pressure

\_\_\_\_Chemotherapy \_\_\_\_Low Blood Pressure

\_\_\_\_Chest Pains \_\_\_\_Kidney Problems

\_\_\_\_Cold Sores / Fever Blisters \_\_\_\_Leukemia

\_\_\_\_Congenital Heart Disorder \_\_\_\_Liver Disease

\_\_\_\_Convulsions \_\_\_\_Parathyroid Disease

\_\_\_\_ Cortisone Medicine \_\_\_\_Pins, Rods, Stints or Shunts

\_\_\_\_Diabetes \_\_\_\_Psychiatric Care

\_\_\_\_Radiation Treatment \_\_\_\_Thyroid Disease

\_\_\_\_Easily Winded \_\_\_\_Renal Dialysis

\_\_\_\_Emphysema \_\_\_\_Rheumatic Fever

\_\_\_\_Epilepsy or Seizures \_\_\_\_Rheumatism

\_\_\_\_Excessive Bleeding \_\_\_\_Scarlet Fever

\_\_\_\_Sickle Cell Disease \_\_\_\_Tuberculosis

\_\_\_\_Tumors or Growths \_\_\_\_ Ulcers

\_\_\_\_Venereal Disease

**List any major illness not listed above:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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**Please check any medications and/or supplements taken in the past 12 months**:

\_\_\_\_Antibiotics or Sulfa Drugs \_\_\_\_Tranquilizer

\_\_\_\_Aspirin (daily) \_\_\_\_Insulin or Diabetes medication

\_\_\_\_Herbal supplements \_\_\_\_High Blood Pressure medicine

\_\_\_\_Heart Medications \_\_\_\_Nitroglycerine

\_\_\_\_Anticoagulants (Coumadin, blood thinners)

\_\_\_\_Contraceptives

**List all medications / supplements you are currently taking:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I authorize my respective healthcare provider or agency to release any needed information to Palm Dental, PLLC. I will notify the doctor of any change in my health or medication at each visit.**

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Signature of Patient or Guardian Date

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Doctor Signature Date