CHRISTINA BLATCHFORD, DMD
GENERAL DENTISTRY

# *Welcome to our Practice!*

*Will you please help us by providing the following confidential information?*

## PATIENT INFORMATION:

Last Name: _____ First Name: _____ Preferred to be called: _____

Date of Birth: _____ Sex: Male / Female E-mail Address: _____

Mailing Address: _____ _ City, State, Zip: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

SS# _____ Driver's License: _____ Occupation: _____

Employer: _____ Address, City State, Zip _____

Spouse's Name: _____ Occupation: _____

Spouse's Address (if different than above): _____, City, State, Zip: _____

Spouse's Employer: _____ Address, City, State, Zip: _____

**Emergency Contact Name: _____ Phone # _____**

**In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:**

**Phone number: _____ Place_____ Time: _____**

**How would you prefer to be contacted for appointment reminders?** ☐ **Email** ☐ **Cell Phone** (You can check both.)

How did you hear about our office? Please check one: ☐ Internet Search ☐ Patient referral ☐ Website ☐ Mailer ☐ Insurance ☐ Other_____

**If you were referred by another guest, who may we thank for their trust in us? _____**

## INSURANCE INFORMATION:

**Primary** Insurance Company: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone # _____

Policy Holder Name: _____ Member's ID # _____ Birth date: _____

Employer Name: _____ Group # or Policy # _____

**Secondary** Insurance Company: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone # _____

Policy Holder Name: _____ Member's ID # _____ Birth date: _____

Employer Name: _____ Group # or Policy # _____

Christina Blatchford, DMD PC

# Patient Medical History

Patient Name: Birth Date:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

| | | |
|---|---|---|
| Are you under a physician's care now? | Yes No | If yes |
| Have you ever been hospitalized or had a major operation? | Yes No | If yes |
| Have you ever had a serious head or neck injury? | Yes No | If yes |
| Are you taking any medications, pills, or drugs? | Yes No | If yes |
| Do you take, or have you taken, Phen-Fen or Redux? | Yes No | If yes |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | Yes No | If yes |
| Are you on a special diet? | Yes No | |
| Do you use tobacco? | Yes No | |

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

| | | |
|---|---|---|
| Other? | ☐ | If yes |
| Do you use controlled substances? | Yes No | If yes |

Do you have, or have you had, any of the following?

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

| | | |
|---|---|---|
| Have you ever had any serious illness not listed | Yes No | If yes |
| Have you ever been advised to take pre-medication before dental treatment? | Yes No | |

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

## DENTAL HEALTH HISTORY

**Name of your Former Dentist: _____ How long since you were last seen? _____**

**What prompted you to seek dental care at this time? _____**

**Are you having discomfort at this time? If so describe: _____**

Is keeping your teeth important to you? [Y] [N] If yes, why? _____

On a scale of 1-10, 10 being the best, where would you rate your smile? _____

On a scale of 1-10, 10 being the best, where you rate your oral health? _____

Have you experienced any of the following problems:

[Y] [N] Bleeding gums
[Y] [N] Have you or your parents suffer(ed) from Gum Disease?
[Y] [N] Bad Breath or sour taste in mouth
[Y] [N] Burning sensations in mouth
[Y] [N] Soreness in jaw
[Y] [N] Is it hard for you to open wide?
[Y] [N] Clicking, popping or other noises in jaw
[Y] [N] Ever been injured in your mouth or head?
[Y] [N] Do you or your parents wear dentures/partials?
[Y] [N] Oral Surgery of any kind?
[Y] [N] Sensitivity to Hot & Cold
[Y] [N] Problems when you chew
[Y] [N] Food catching between teeth
[Y] [N] Clenching or Grind your Teeth
[Y] [N] Easily gag
[Y] [N] Do you feel your teeth fit together well
[Y] [N] Stiff neck/throat muscles
[Y] [N] Did you ever wear braces?
[Y] [N] Do you smoke or chew tobacco?

Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you? _____

_____

Is the brightness of your teeth important to you? [Y] [N]

If you could change anything about your smile which of the following would you want?

| | | |
|---|---|---|
| [Y] [N] Whiter | [Y] [N] Close space or spaces | [Y] [N] Replace chipped teeth |
| [Y] [N] Replace missing teeth | [Y] [N] Replace old crowns | [Y] [N] Remove silver fillings |
| [Y] [N] Remove Stains/Spots on teeth | [Y] [N] Excess showing of Teeth | [Y] [N] Replace old plastic filling(s) |
| [Y] [N] Straighter | [Y] [N] Less Gum showing | [Y] [N] Reshape/resize my teeth |

Where do you see your overall oral health and/or your smile in the next 5 to 10 years? _____

_____ _

**Please circle the following which are important to you when making your dental health decision.**

| | | |
|---|---|---|
| Convenience | Appearance | Relationship with Dental Team |
| Finances | Time | Quality of care |
| What insurance covers | Health | Detailed treatment explanations |
| Fear or Anxiety | Comfort | Technology |