Welcome to Flint Family Dentistry

Patient Name: _____ Date of Birth_____ Social Security #_____

Address: _____ Sex: Male Female

Cell Phone: _____Home Phone: _____ Insurance Co._____

Insurance ID# _____ Secondary Insurance _____2nd Insurance ID # _____

Emergency contact name _____ Phone# _____Relation:_____

How did you hear about us _____ Do you have Children? Yes No How many?_____

Person responsible for account _____ Relation _____ Phone# _____

Social Security # _____ E-mail address: _____Marital Status_____

PATIENT MEDICAL HISTORY

Physician name: _____ Office Phone_____ date of last exam _____

1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operation, or serious illness? Yes No
3. Are you taking any medications including non prescription medicines? Yes No
   If yes, what medications: _____
   _____
4. Have you ever taken Fen-Phen/Redux? Yes No
5. Do you use tobacco? Yes No
6. Do you use Cocaine or illegal substance? Yes No
7. Are you wearing contact lenses? Yes No
8. Do you have a persistent cough or throat clearing, not associated with known illness? Yes No
9. Are you allergic or have had reactions to
   a. Local anesthetics Yes No
   b. Penicillin or other antibiotics Yes No
   c. Sulfa Drugs Yes No
   d. Barbiturates Yes No
   e. Sedatives Yes No
   f. Iodine Yes No
   g. Aspirin Yes No
   h. Latex Yes No
   i. Other _____
10. Women Only:
    a. are you pregnant or think you may be pregnant? Yes No
    b. Are you Nursing? Yes No
    c. Are you on birth control pills? Yes No

Do you have any of the following?

__High Blood pressure	__Heart disease	__Chest Pain	__Heart attack
__Cardiac pacemaker	__Easily winded	__Rheumatic fever	__Heart murmur
__Stroke	__Swollen ankles	__Angina	__Hay fever
__Fainting/Seizures	__Frequently tired	__Tuberculosis	__Asthma
__Low blood pressure	__Emphysema	__Anemia	__Radiation therapy
__Glaucoma	__Epilepsy/convulsions	__Cancer	__Recent weight loss
__Leukemia	__Arthritis	__Liver disease	__Diabetes
__Joint replacement/Implant	__Heart trouble	__Kidney diseases	__Thyroid problems
__Hepatitis/Jaundice	__Respiratory problems	__Aids or HIV	__Chemotherapy
__Stomach troubles/ulcers	__Sexually transmitted disease	__Back problems	

PATIENT DENTAL HISTORY

1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to sweet, sour, hot or cold? Yes No
3. Do you have lumps or sores in or near your mouth? Yes No
4. Have you had head, neck or jaw injuries? Yes No
5. Do you clench or grind your teeth? Yes No
6. Have you had prolonged bleeding following extractions? Yes No
7. Do you bite your lip or cheeks frequently? Yes No
8. Have you ever had difficult extractions? Yes No
9. Have you had any orthodontic work? Yes No
10. Do you have frequent headaches? Yes No
11. How would you rate your smile? 1 2 3 4 5