Patrick W. Carroll, D.D.S., F.P.F.A. General Dentistry

Welcome!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

PATIENT'S NAME: _____ Date: _____
❍ Male ❍ Female *(Last)* *(First)* *(Middle)*

Patient prefers to be called by the name: _____ E-mail address: _____

Mailing Address: _____ Home Phone #: _____
(Street or box)

_____ Cell/Mobile Phone#: _____
(City) *(State)* *(Zip)*

Work/Other Phone #: _____

❍ Single ❍ Married ☞ Name of Spouse: _____
Patient's Social Security Number: _____ ❍ Divorced ❍ Widowed ❍ Separated

Patient's Birthdate: _____ Referred to our office by: _____

DENTAL HISTORY: *Please give a full explanation below to any questions which apply.*

Why have you come to the dentist today? _____

Any unhappy past dental experiences? _____

Have there been any complications with tooth extractions or other dental surgeries? _____

If we could do *anything* to enhance the smile's appearance, what would you like us to do? _____

_____

Do the gums bleed when brushing/flossing? ❍ Yes Any past gum treatments: _____

Have the teeth been straightened? ❍ Yes Is there a problem with clenching or grinding of the teeth? ❍ Yes

Have you noticed a lump or swelling in the mouth? ❍ Yes Comments: _____

Is fear of the dentist a substantial problem? ❍ Yes Comments: _____

How long since last dental visit? _____ What was done then? _____

OVER, PLEASE. THERE'S A LOT MORE WE NEED TO KNOW!

Name _____ Birthdate _____ Phone _____

Address _____Emergency Contact Name: _____

MEDICAL HISTORY: *Please give a full explanation below to any questions which apply.*

Currently under a physician's care? ❍ Yes Comments: _____

_____ Height _____

Physician's name & address: _____ Weight _____

DRUGS TAKING NOW	DOSAGE	DRUGS TAKING NOW	DOSAGE

Report any trouble with prolonged bleeding requiring special treatment after past tooth extractions or other surgery:

_____

Describe any unusual reaction or allergy to an anesthetic or drug: _____

FOR WOMEN: Are you pregnant? ❍ Yes If yes, what month of pregnancy? _____
Are you nursing? ❍ Yes

HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS IN THE LAST 5 YEARS?

❍Actonel ❍Aredia ❍Bisphosphonate ❍Bondronat ❍Bonefos ❍Boniva ❍Didronel ❍Fosamax ❍Neridronate ❍Olpadronate ❍Skelid ❍Zometa

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

Yes
- ❍ Rheumatic fever
- ❍ Infectious hepatitis
- ❍ Jaundice
- ❍ Tuberculosis
- ❍ Diabetes
- ❍ Epilepsy
- ❍ Heart disease or attack
- ❍ Blood pressure trouble
- ❍ Stroke
- ❍ Glaucoma
- ❍ Kidney or liver trouble
- ❍ Asthma

Yes
- ❍ Mitral valve prolapse
- ❍ Angina
- ❍ Pacemaker
- ❍ Artificial joints
- ❍ Artificial valves
- ❍ Ulcers
- ❍ Emphysema
- ❍ Thyroid disease
- ❍ Cancer
- ❍ X-ray treatment for cancer
- ❍ Cobalt treatment for cancer
- ❍ Chemotherapy

Yes
- ❍ HIV+ / AIDS
- ❍ Hemophilia
- ❍ Cold sores / fever blisters
- ❍ Psychiatric treatment
- ❍ On special diet
- ❍ Shortness of breath
- ❍ Swelling of ankles during day
- ❍ Congenital heart defect
- ❍ Heart surgery
- ❍ Anemia
- ❍ Must be propped up to sleep
- ❍ Severe or frequent headaches

Comments on above, or other, medical or dental problems:

The information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in the medical status. I understand that payment is due in full at the time of treatment unless prior arrangements have been approved. *I authorize the dental staff to perform any necessary dental services, with my informed consent, that I may need during diagnosis and treatment.*

_____
Signature *Date*