Precision Dental
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PRECISION DENTAL
GENERAL & COSMETIC DENTISTRY

Patient Personal Information

Title		Preferred Name		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				Emergency Contact		Emergency Phone #	
Email				Student		SSN	
Health Care Guardian Name				School Name			
Health Care Guardian Phone #				Referral Type			

Person responsible/guarantor for paying bills

Title		Preferred Name		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				SSN			
Email							

Do you have Primary Dental Insurance? __ Yes __ No				Do you have Secondary Dental Insurance? __ Yes __ No			
Group No/Name				Group No/Name			
Insurance Name				Insurance Name			
Phone #				Phone #			
Employer Name				Employer Name			
Subscriber Last, First				Subscriber Last, First			
Subscriber Address				Subscriber Address			
City, State, Zip				City, State, Zip			
Relationship to Patient		Birth Date		Relationship to Patient		Birth Date	
Subscriber ID				Subscriber ID			

Patient Medical Information

ALLERGIES

Allergic to Antibiotics?

- ☐ Y ☐ N Amoxicillin
- ☐ Y ☐ N Azithromycin
- ☐ Y ☐ N Bactrim
- ☐ Y ☐ N Clindamycin
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Tetracycline
- ☐ Y ☐ N Other: See Medical Questions

Allergic to Other Medications?

- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates/Sleeping Pills
- ☐ Y ☐ N Codeine/Other Narcotics
- ☐ Y ☐ N Epinephrine
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Stroke TIA

Breathing (Respiratory) Health

- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N COPD
- ☐ Y ☐ N Difficulty Breathing
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Snoring
- ☐ Y ☐ N Tuberculosis

Cancer

- ☐ Y ☐ N Cancer/Tumor or Growth
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Leukemia
- ☐ Y ☐ N Urinate Frequently

Eye, Ear, Nose, Throat

- ☐ Y ☐ N Blindness
- ☐ Y ☐ N Color Blindness
- ☐ Y ☐ N Contact Lenses
- ☐ Y ☐ N Deaf/ Hearing Impairment
- ☐ Y ☐ N Ear Infections
- ☐ Y ☐ N Fever Blisters
- ☐ Y ☐ N Frequent Dry Mouth/Sjogren's
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Glaucoma
- ☐ Y ☐ N Mouth Ulcers
- ☐ Y ☐ N Throat Infections

Skin

- ☐ Y ☐ N Hives
- ☐ Y ☐ N Hay Fever
- ☐ Y ☐ N Infections - Recurrent
- ☐ Y ☐ N Joint Replacement/Surgery
- ☐ Y ☐ N Malnutrition
- ☐ Y ☐ N Metal Pins/Plates
- ☐ Y ☐ N Night Sweats
- ☐ Y ☐ N Nursing
- ☐ Y ☐ N Organ Transplant
- ☐ Y ☐ N Persistent Swollen Glands
- ☐ Y ☐ N Physical Disability
- ☐ Y ☐ N Pregnant
- ☐ Y ☐ N Sleep Disorders
- ☐ Y ☐ N Spina Bifida
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N TMJ Problems

Y N Ibuprofen
Y N Local Anesthetics
Y N Morphine
Y N NSAID (Advil/Motrin)
Y N Sulfa Drugs
Y N Valium
Y N Other: See Medical Questions

Other Types of Allergies?

Y N Environmental Allergies
Y N Food Allergy
Y N Gluten
Y N Household Bleach
Y N Iodine
Y N Latex Rubber
Y N Metals or Plastics
Y N Nuts
Y N Seasonal Allergies
Y N Other: See Medical Questions

MEDICAL CONDITIONS

Heart (Cardiac) Health

Y N Angina
Y N Arteriosclerosis
Y N Atrialfibrilation (Afib)
Y N Cardiovascular Disease
Y N Chest Pain Upon Exertion
Y N Cholesterol - High
Y N Congenital Heart Defect
Y N Congestive Heart Failure
Y N Damaged/Artificial Heart Valve
Y N Heart Attack
Y N Heart Murmur
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Previous Endocarditis
Y N Radiation Treatment

Blood (Circulatory) Health

Y N Abnormal Bleeding
Y N Anemia
Y N Blood Clotting Problems
Y N Blood Pressure - High
Y N Blood Pressure - Low
Y N Blood Thinners
Y N Blood Transfusion
Y N Hemophilia
Y N Jaundice
Y N Kidney Problems

Brain (Neurological) Health

Y N ADHD/ADD
Y N Alcoholism/Drug Addiction
Y N Alzheimer's Disease
Y N Anorexia
Y N Autism Spectrum Disorder (ASD)
Y N Bulimia
Y N Claustrophobia
Y N Epilepsy/ Seizures
Y N Frequent Headaches
Y N Head Injury
Y N Mental Health Conditions
Y N Migraines
Y N Neurological Disorders
Y N Psychiatric/Emotional Issues

Digestive Health

Y N Acid Reflux/ GERD
Y N Bladder Trouble
Y N Gall Bladder Trouble
Y N Gastrointestinal Disease
Y N Persistent Diarrhea
Y N Stomach Ulcers/Colitis
Y N Skin Rash

INFECTIONS & DISEASES

Autoimmune Disease

Y N AIDS/HIV Infection
Y N Autoimmune Disease
Y N Lupus
Y N Rheumatic Fever
Y N Rheumatoid Arthritis

Bacterial

Y N Chlamydia, Gonorrhea, Syphilis
Y N Scarlet Fever

Viral Infections

Y N Chicken Pox
Y N Hepatitis A
Y N Hepatitis B
Y N Hepatitis C
Y N Herpes
Y N Prior Hepatitis
Y N Shingles

Chronic Disease

Y N Arthritis
Y N Diabetes Type 1
Y N Diabetes Type 2
Y N Liver Disease
Y N Osteoporosis

OTHER CONDITIONS

Y N Ankles Swell
Y N Bells Palsy
Y N Blood Sugar - Low
Y N Chronic Pain
Y N Difficulty Healing
Y N Down Syndrome
Y N Fainting Spells
Y N Fibromyalgia
Y N Unusual Weight Loss
Y N Other: See Medical Questions

TAKEN/TAKING OR TREATED WITH

Bisphosphonates

Y N Actonel
Y N Aredia
Y N Fosamax
Y N Zometa
Y N Other Bisphosphonates

OTHER MEDICATIONS

Y N Aspirin Daily
Y N Birth Control
Y N COVID-19 Vaccine Received
Y N Diet Pills
Y N Herbal Supplements
Y N Hormone Replacements
Y N Other Blood Thinners
Y N Premedicate

HABITS

Y N Tobacco Habit

CHILDREN'S HABITS

Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust

Additional Comments

Dental Questionnaire

What is the purpose of today's visit? _____

Dental History

Name of Previous Dentist? _____

When was the patient's last cleaning? _____

When were the patient's last dental x-rays taken? _____

Does the patient brush their teeth daily? _____

Does the patient floss their teeth daily?	
Does the patient have any loose teeth, broken fillings, or jaw pain? Explain.	
Has the patient ever had trauma or injury to the mouth, teeth, or chin? Explain.	
Has the patient had an unpleasant dental experience or a problem with past dental work? Explain.	
Is the patient happy with the appearance of their teeth (i.e. color, position or smile)? Explain.	
Orthodontic Questions	
Has the patient ever been evaluated for or had orthodontic treatment before?	
List any brass or woodwind instruments played:	
Have adenoids or tonsils been removed?	

Medical Questionnaire

Describe the patient's current physical health.	
Is the patient currently under the care of a physician?	
Physician's Name:	
Office Telephone & Office Address:	
Has there been a recent change to the patient's health? Explain.	
Has the patient been hospitalized or had a serious illness within the past 5 years? Explain.	
Is the patient currently taking any prescription, over the counter, or recreational drugs?	
List Medications:	
Pharmacy Name and Address:	
Pharmacy Phone Number:	
Pharmacy Address	
Is there anything the patient would like to discuss with the doctor in private?	
Any disease, condition, or problem not listed? Please list.	
For Children Only:	
Are immunizations current?	
Has puberty begun?	
Has menstruation begun?	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**

Dentist Signature **Date**