COLBY PACIFIC FAMILY DENTISTRY

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Thank you for choosing our office. In order to serve you properly, please answer all questions on BOTH sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential.

PATIENT'S NAME_____ PREFERRED NAME_____

☐ Male ☐ Female ☐ Other Social Security No._____-_____-_____ Birthdate_____/_____/_____

Mailing Address_____ Email _____

City_____ State_____ Zip Code_____ Home Phone No. (_____) _____

Cell Phone No. (_____)_____ How should we contact you? ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Text

Patient Occupation_____ Employer_____ Work Phone (_____)_____

Name of Spouse_____ Birthdate_____/_____/_____ SSN_____

Spouse Occupation_____ Employer_____ Work Phone (_____) _____

**IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?** (Other than someone living with you)

Name_____ Home Ph. No. (_____)_____ Work Ph. No. (_____)_____

Relationship to patient _____

**WHOM MAY WE THANK FOR REFERRING YOU TO US?** _____

Do you have any hobbies or interests that you would like to share? _____

_____

Is there anyone you would like to give us permission to speak to about your dental care? _____

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or amount that my insurance does not cover. _____
*Initials*

**Person responsible for payment:** _____

## Primary Dental Insurance

Employee _____
Relationship to Patient _____
Employer _____
Insurance Co. _____ Group# _____
Insurance Phone No. _____
Insurance Member ID # _____
Subscriber D.O.B. _____

## Secondary Dental Insurance

Employee _____
Relationship to Patient _____
Employer _____
Insurance Co. _____ Group# _____
Insurance Phone No. _____
Insurance Member ID # _____
Subscriber D.O.B. _____

(Turn Over)

# Dental History

Are you having any pain or discomfort? ☐ Yes ☐ No
Are you nervous about having dental treatment? ☐ Yes ☐ No
Have you ever had a bad dental experience? ☐ Yes ☐ No
Do you experience difficulty / pain when chewing, talking or using your jaw? ☐ Yes ☐ No
Do you have noises in your jaw joint? ☐ Yes ☐ No
Does your bite feel uncomfortable or unusual? ☐ Yes ☐ No
Have you ever had an injury to your head or jaw? ☐ Yes ☐ No
Have you been treated for a jaw joint problem? ☐ Yes ☐ No
Chief dental concern:_____

_____

Do you have dry mouth? ☐ Yes ☐ No
Do your teeth ever feel loose? ☐ Yes ☐ No
Does food often catch in-between your teeth? ☐ Yes ☐ No
Do your gums bleed? ☐ Yes ☐ No
Have you ever had periodontal (gum) disease? ☐ Yes ☐ No
Are your teeth sensitive to cold/heat/sweets? ☐ Yes ☐ No
Do you take antibiotics for a health condition before each dental visit? ☐ Yes ☐ No
Previous Dentist's Name and Location:_____

_____

Are you happy with the way your smile looks? ☐ Yes ☐ No
If not, what would you change?_____

# Health History

Have you been hospitalized or seen a Medical Doctor in the past 2 years? ☐ Yes ☐ No
*If so, for what condition?*_____

*Physician's Name:*_____
*Date and reason of last visit:*_____

Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel, etc) ☐ Yes ☐ No
Name of and date started?_____
WOMEN: Are you pregnant or nursing? ☐ Yes ☐ No
Do you smoke, vape or use chewing tobacco? (circle one) ☐ Yes ☐ No

Are you currently taking any prescriptions, over the counter drugs or herbal supplements? ☐ Yes ☐ No
***If so, please list and include the reason for taking:***

_____

_____

_____

Do you take blood thinners? ☐ Yes ☐ No
Name of and date started: _____
Please list any serious medical condition(s) that you currently have or have had in the past: _____

## Please Check any of the following which you have now or have had in the past.

☐ **No Medical Conditions**

☐ Acid Reflux/GERD/heartburn
☐ Angina Pectoris (Chest Pain)
☐ Heart Disease/Attack/Stroke
☐ Heart Failure
☐ High/Low Blood Pressure (circle one)
☐ Congenital Heart Defect
☐ Heart Surgery
☐ Heart Pacemaker
☐ Artificial Heart Valve
☐ Diabetes, Type I ☐ II ☐
☐ Blood Transfusion/Anemia
☐ Sickle Cell Disease
☐ Bruise Easily
☐ Hemophilia/Blood Disorder
☐ Liver Disease/Yellow Jaundice
☐ Kidney Failure/Dysfunction
☐ Thyroid Disease/Condition
☐ Eating Disorder
☐ Glaucoma
☐ Chemotherapy for Cancer
☐ Radiation Treatment for Cancer
☐ Tuberculoses (TB)
☐ Arthritis/Rheumatism/Lupus
☐ Cortisone Medicine/Steroids
☐ STDs/HPV
☐ A.I.D.S./H.I.V.
☐ Hepatitis: A, B, C
☐ Frequent Headaches
☐ Artificial Joints (Hip, Knee, etc.)
☐ Canker Sores/Cold Sores (circle one)
☐ Fainting/Dizzy Spells
☐ Epilepsy/Seizures
☐ Hay Fever/Sinus Trouble
☐ Allergies/Hives
☐ Shingles
☐ Anxiety Disorder
☐ Psychiatric Treatment
☐ Drug/Alcohol Addiction
☐ Emphysema
☐ Asthma
☐ Depressed Immune System
☐ Organ Transplant
☐ Osteoporosis
☐ High Cholesterol
☐ Cancer
☐ Depression
☐ Sleep Apnea
☐ Other _____

### Sleep/Airway Issues

Do you tend to be a mouth-breather? ☐ Yes ☐ No
Are you often tired or sleepy during the day? ☐ Yes ☐ No
Do you awaken multiple times during the night? ☐ Yes ☐ No
Do you feel well-rested in the morning? ☐ Yes ☐ No
Do you often snore at night? ☐ Yes ☐ No
Has anyone observed you stop breathing, gasping or struggling to breathe while asleep? ☐ Yes ☐ No

## Are you allergic to or have you reacted adversely to any of the following?

*Please check any that apply.*

☐ **No Allergies**

☐ Codeine
☐ Aspirin
☐ Triazolam
☐ Percodan
☐ Tylenol
☐ Valium
☐ Sulfa
☐ Ibuprofen
☐ Nitrous Oxide
☐ Penicillin
☐ Erythromycin
☐ Tetracycline
☐ Other Antibiotics
☐ Latex
☐ Metals/Jewelry
☐ Local Anesthetic
☐ Amoxicillin

*List any other allergies here:*_____

I understand that the information that 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 my medical status or medications.

**Patient Signature**_____ **Date**_____

**Doctor Signature**_____ **Date**_____