



WELCOME TO FEATHER TOUCH DENTISTRY

Patient Information

Name :		Today's Date :
Email address :		I prefer to be called :
Date of Birth :	SSN :	Phone # :
Current Address :		Driver's Licence # :
City :	State :	Zip Code :
Marital Status : <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Seperated		

Employment Information

Current Employer :		
Employer Address :		How Long :
Phone :	Fax :	Email :
City :	State :	Zip :
Position :	When and where best time to reach you :	

Emergency Contact

Name of the relative not living with you :		Relationship :
Address :		Phone :
City :	State :	Zip Code :

Spouse Information

Name :		
Date of Birth :	SSN :	Phone # :

Spouse's Employment Information

Current Employer :		
Employer Address :		How Long :
Phone :	Fax :	Email :
City :	State :	Zip :

Insurance (Primary)

Dental Coverage :	<input type="checkbox"/> YES:	<input type="checkbox"/> NO
Insurance Co. Name :		
Insurance Co. Address :		
Insurance Co. Phone :		
Group # (Plan, Local or Policy #) :		
Insured's Name :	Relation (or "Self") :	
Insured's Date of Birth :	Insured's SSN :	
Insured's Employer :		
Employer Address :		

Insurance (Secondary)

Dental Coverage :	<input type="checkbox"/> YES:	<input type="checkbox"/> NO
Insurance Co. Name :		
Insurance Co. Address :		
Insurance Co. Phone :		
Group # (Plan, Local or Policy #) :		
Insured's Name :	Relation (or "Self") :	
Insured's Date of Birth :	Insured's SSN :	
Insured's Employer :		
Employer Address :		

Who may we thank for referring you:		
Have any of your family members been seen by us? If so, who? :		Approx.Date :

Medical History

Do you have a personal physician : YES NO

Physician's Name :

Physician's Phone #:

Date of Last Visit :

Your current health is : GOOD FAIR POOR

Currently under the care of physician : YES NO Are you allergic to any of these ?

Please Explain :

<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N Latex
<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin
<input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline
<input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin	<input type="checkbox"/> Y <input type="checkbox"/> N Other
<input type="checkbox"/> Y <input type="checkbox"/> N Jewelry/Metals	

Do you Smoke/Use tobacco ? : YES NO

Are you taking any prescription/
over-the-counter drugs ? : YES NO

Please List :

Why have you come to us today ?
Are you currently in pain? YES NO

FOR WOMEN

Are you taking birth-control pills? : YES NO

Do you require antibiotics
before dental treatment? YES NO

Are you pregnant? : YES NO Weeks :

Your current dental health is : Good Fair Poor

Are you nursing ? : YES NO

Have you ever had the following diseases or
medical problems ? :

<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes/Fever blisters
<input type="checkbox"/> Y <input type="checkbox"/> N AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N HIV - Positive Negative (circle one)
<input type="checkbox"/> Y <input type="checkbox"/> N Allergies/Hives	
<input type="checkbox"/> Y <input type="checkbox"/> N Angina Pectoris	<input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for any reason ?
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	
<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis Bones/Joints/Valves	<input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement
	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney problems
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Liver disease
<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Low blood pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Bruises easily	<input type="checkbox"/> Y <input type="checkbox"/> N Mental disorder
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer/Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse
<input type="checkbox"/> Y <input type="checkbox"/> N Cold Sores	<input type="checkbox"/> Y <input type="checkbox"/> N Nervous disorder
<input type="checkbox"/> Y <input type="checkbox"/> N Solitis	<input type="checkbox"/> Y <input type="checkbox"/> N Pectoris
<input type="checkbox"/> Y <input type="checkbox"/> N Cognital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric problems
<input type="checkbox"/> Y <input type="checkbox"/> N Cortisone	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment
<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Shingles
<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty breathing/ Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N Sickly cell disease/Traits sinus problems
	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke thyroid problems
<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N Tonsilitis
<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy/Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)
<input type="checkbox"/> Y <input type="checkbox"/> N Excessive bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Tumors / Growth
<input type="checkbox"/> Y <input type="checkbox"/> N Fainting spells	<input type="checkbox"/> Y <input type="checkbox"/> N Ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N Frequent headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease
<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Others :
<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever	
<input type="checkbox"/> Y <input type="checkbox"/> N Head Injuries	
<input type="checkbox"/> Y <input type="checkbox"/> N Heart attack/failure/ Alignment/Murmer	
<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia	
<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis - A B C	

Have you ever had any serious/difficult problem
associated with any previous dental work?:
 YES NO

Do you floss daily ? YES NO

Do you brush daily ? YES NO

Type of bristles on your tooth brush:
 Hard Medium Soft

Do you ever had gum treatment ? YES NO

Ever had periodontal disease ? YES NO

Do your gums ever bleed ? YES NO

Do your gums ever itch ? YES NO

Do you know or have you experienced pain/
discomfort in your jaw joint ? (TMJ / TMD)
 YES NO

Are your teeth sensitive to cold, hot or anything else ?

Do you have mobility in your teeth ? YES NO

Do you still have wisdom teeth ? YES NO

Do you like fresher breath ? YES NO

Do you like whiter teeth ? YES NO

Are you happy with the way your smile looks?
 YES NO

If not what would you change ?

I understand that the information I have given today is correct to the best of my knowledge. I also understood 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. I authorize the dental staff to perform this office of any necessary dental service that I may need during diagnosis and treatment, with my informed consent.

Signature :

Date :

For Office Use Only

I verbally reviewed the medical/dental information with the patient named herein

Initials :

Date :

Doctor's comments :