AVON DENTAL

ABOUT YOU

Today's Date: _____/_____/_____

Name:_____
LAST FIRST MIDDLE

I Prefer to be called:_____

Birthdate: _____/_____/_____ Age_____ ☐ Male

Social Security #_____ _____ _____ ☐ Female

Check one: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address:_____
Street/P.O. Box Apt. /Condo#

_____
City State Zip Code

Email Address:_____

Home Phone:(____)_____Cell:(____)_____

Work Phone:(____)_____ Ext: _____

How may we remind you of your upcoming appointments?

☐ Phone Call ☐ Email ☐ Text Message

Employer:_____

Occupation:_____ How long there?_____

_____

When and where are the best times to reach you?

_____

Whom may we thank for referring you?_____

Other family members seen by us?_____

_____

_____

Name of person who lives nearby
we should notify in the event of an emergency:_____

Relationship:_____

Cell phone:(____)_____

Other phone:(____)_____

DENTAL HISTORY

Why have you come to the dentist today?_____

_____

_____

Are you currently in pain? ☐ Yes ☐ No

Previous Dentist: _____

Date of last dental care_____

Have you had any serious problem associated with any previous dental treatment? ☐ Yes ☐ No

Your current dental health is? ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times a week do you floss?_____

How many times a day do you brush?_____

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

MEDICAL HISTORY

Do you have a personal Physician? ☐ Yes ☐ No

Physician's Name:_____

Phone:(____)_____

Date of last visit: _____/_____/_____

Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes please explain:_____

_____

Are you currently under a physician's care? ☐ Yes ☐ No

If yes please explain:_____

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

How long?_____ How often?_____

Please list all medications being taken (Prescription or herbal):

_____

_____

_____

_____

Check whether you have ever had any of the following:
YES/NO

- ☐ ☐ Artificial Bones/Joints
- ☐ ☐ Artificial Valves
- ☐ ☐ Asthma
- ☐ ☐ Arthritis
- ☐ ☐ Autism/Asperger's
- ☐ ☐ Bisphosphonates
- ☐ ☐ Blood Transfusion
- ☐ ☐ Cancer/Chemotherapy, explain_____
- ☐ ☐ Congenital Heart Defect
- ☐ ☐ Rheumatic Fever, what type_____
- ☐ ☐ Diabetes, what type_____
- ☐ ☐ Difficulty Breathing
- ☐ ☐ Drug/Alcohol Abuse
- ☐ ☐ Emphysema
- ☐ ☐ Endocarditis
- ☐ ☐ Epilepsy/Seizures
- ☐ ☐ Fever Blisters/Cold Sores
- ☐ ☐ Heart Attack, when?_____
- ☐ ☐ Stroke, when?_____
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Taking blood thinners
- ☐ ☐ Pacemaker, when placed_____
- ☐ ☐ Heart Murmur
- ☐ ☐ Hemophilia/Abnormal Bleeding
- ☐ ☐ Hepatitis, what type?_____
- ☐ ☐ High/Low Blood Pressure
- ☐ ☐ HIV/AIDS
- ☐ ☐ Sinus Problems
- ☐ ☐ Ulcers/Colitis
- ☐ ☐ Sexually transmitted disease
- ☐ ☐ Tuberculosis
- ☐ ☐ Glaucoma

Please list any serious medical problems you've ever had:

_____

_____

Are you allergic to any of the following :

- ☐ ☐ Aspirin
- ☐ ☐ Codeine
- ☐ ☐ Penicillin
- ☐ ☐ Latex
- ☐ ☐ Erythromycin
- ☐ ☐ Other_____

For Women:

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

If "Yes" what week?_____

Are you nursing? ☐ Yes ☐ No

I understand this information I have given today is correct to the best of my knowledge and that this information will be held in confidence. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

Signature_____

Thank you for filling out this form. It will help us treat you more effectively. If you have any questions at any time, please ask us. We are happy to help.

For Office Use Only

Doctor's comments:

_____

_____

_____

_____

_____

_____

_____