WELCOME TO HANDCRAFTED DENTISTRY

Drs. Singleton & Eaker
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NAME: ____ **SEX:** M F

NAME YOU PREFER TO BE CALLED: __________________ **DATE OF BIRTH:** ___/___/______

HOME ADDRESS: ____

____ **ZIP CODE:** ______________

HOME TELEPHONE: _______________ **CELL PHONE:** _____________________________

SSN: ________________________ **EMAIL ADDRESS:** ___________________________

EMERGENCY CONTACT: _______________________ **PHONE NUMBER:** _______________

EMPLOYER: ____________________________**OCCUPATION:** ________________________

NAME OF SPOUSE/PARENT: ______ **PARTY RESPONSIBLE FOR PAYMENT:** ____________

INSURANCE CO. NAME: _______________________**SUBSCRIBER ID#:** _______________

WHO MAY WE THANK FOR REFERRING YOU? ____________________________________

YOUR HOBBIES, INTERESTS, PETS, ETC._______________________________________

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MEDICAL AND DENTAL HISTORY

GENERAL HEALTH: EXCELLENT GOOD FAIR POOR

PHYSICIAN'S NAME: ______________________________ **PHONE #:** __________________

WHAT IS THEIR SPECIALTY? ____

YEAR OF LAST PHYSICAL: _____________

LIST ALL MEDICINES & DOSAGES YOU ARE TAKING NOW (can also bring or email list)

____

____

DO YOU HAVE ALLERGIES TO: PENICILLIN CODEINE DENTAL ANESTHETIC
LATEX **OTHER:** ____

DO YOU TAKE MEDICINE OR INJECTIONS FOR OSTEOPOROSIS?
(Fosamax, Romosozumab, other?) ____

WOMEN: PREGNANT? ______ **IF YES, HOW MANY WEEKS?** __________ **NURSING?** ____

HAVE YOU BEEN TOLD BY ANYONE THAT YOU NEED TO BE PREMEDICATED BEFORE DENTAL TREATMENT? ____________ IF YES, WHY?______________________________

PLEASE CHECK (YES OR NO) IF YOU HAVE HAD ANY OF THESE CONDITIONS:

	YES	NO		YES	NO
HEART TROUBLE/MURMUR	YES	NO	FAINTING SPELLS	YES	NO
MITRAL VALVE PROLAPSE	YES	NO	RHEUMATIC FEVER	YES	NO
HIGH / LOW BLOOD PRESSURE	YES	NO	JOINT REPLACEMENT	YES	NO
PACEMAKER / CHEST PAIN	YES	NO	HERPES/COLD SORES	YES	NO
ANEMIA / ABNORMAL BLEEDING	YES	NO	GONORRHEA/SYPHILIS	YES	NO
DIABETES type I / II	YES	NO	LIVER/KIDNEY TROUBLE	YES	NO
POSITIVE TUBERCULOSIS TEST	YES	NO	STROKE	YES	NO
ASTHMA OR HAY FEVER	YES	NO	EPILEPSY/SEIZURES	YES	NO
HEPATITIS/JAUNDICE	YES	NO	GI ISSUES	YES	NO
ARTHRITIS	YES	NO	AIDS/ HIV INFECTION	YES	NO
GLAUCOMA	YES	NO	THYROID PROBLEMS	YES	NO
SINUS PROBLEMS	YES	NO	CANCER TX/ RADIATION	YES	NO
SHORTNESS OF BREATH	YES	NO	REFLUX/ULCERS	YES	NO
SLEEP APNEA/DISORDER	YES	NO	OTHER ____________________ ____________________		

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IT IS NATURAL TO HAVE SOME ANXIETY ABOUT DENTAL TREATMENT. IS THERE ANYTHING WE CAN DO OR NOT DO TO MAKE YOUR VISITS MORE PLEASANT? ____________________
____

HAS THERE BEEN ANY RECOMMENDED DENTAL CARE THAT YOU HAVE YET TO COMPLETE?

____

HOW CAN WE HELP YOU? ____

APPROXIMATE DATE OF LAST DENTAL VISIT: ____

WOULD YOU LIKE FOR US TO REQUEST YOUR PREVIOUS DENTAL RECORDS? YES NO

I BRUSH MY TEETH______TIME(S) PER DAY

FLOSS ________X PER WEEK OR NEVER

OTHER DENTAL PRODUCTS YOU USE:____

CHECK ALL THAT APPLY TO YOU:

X-RAYS TAKEN IN LAST 3 YEARS: IF YES, CHECK ONE OR MORE BELOW
BITEWINGS PANORAMIC FULL SERIES I CAN'T REMEMBER
ORTHODONTIC TREATMENT (BRACES). AT WHAT AGE? _______________
DENTURES THAT ARE REMOVABLE. IF YES, CHECK (TOP BOTTOM BOTH)
SOME TEETH ARE SENSITIVE. IF YES, CHECK (HOT COLD SWEETS PRESSURE)
TOOTHACHE OR PAIN. IF YES, CHECK (TMJ/JAW JOINTS FACE NECK SINUSES)
JAW JOINT CLICKS. IF YES, CHECK (ON CHEWING OPENING CLOSING IN MORNING)
CLENCH OR GRIND TEETH. IF YES, CHECK (DAY NIGHT)
HAVE NIGHTGUARD
I RATE MY SMILE (ON A SCALE FROM 1-10 WITH 1 BEING POOR AND 10 BEING GREAT): ___________________________________
I WOULD LIKE TO CHANGE THE APPEARANCE OF SOME TEETH (please describe below)
____
FOOD CATCHES BETWEEN SOME TEETH.
GUMS BLEED ON BRUSHING OR FLOSSING.
I HAVE BEEN TOLD I HAVE GUM DISEASE. (Treatment date, if any______________________)
I HAVE DRY MOUTH. IF YES, CHECK (MODERATE SEVERE)
IS THERE ANYTHING ELSE YOU WOULD LIKE FOR US TO KNOW?:
____
____

I certify that the above information is correct.

PATIENT (OR GUARDIAN) SIGNATURE: ______________________________ DATE: ___________

THANK YOU!

When you are finished with these forms, please email them to info@handcrafteddentistry.com