FoxViewDental
Cosmetic | Restorative | Implant | Sedation

Patient Information

Please take a few minutes to fill out this form as completely as you can.
We look forward to working with you in maintaining your dental health.

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Work Phone _____ Email _____

Sex ☐M ☐F Age _____ Birth Date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Insurance Co. _____ Business Phone _____

Spouse _____ Spouse D.O.B. _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Phone: (W) _____ (C) _____ (H) _____

Medical History

Physician's Name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operation in the last 5 years ☐Y ☐N

If Yes, describe _____

Women: Are you pregnant ? ☐Y ☐N Nursing? ☐Y ☐N Taking birth control Pills? ☐Y ☐N Pre-med ☐Y ☐N

Check (√) yes or no whether you have had any of the following pre-med questions:

☐Y ☐N AIDS/HIV
☐Y ☐N Anaphylaxis
☐Y ☐N Anemia
☐Y ☐N Arthritis _____
☐Y ☐N Artificial heart valves
☐Y ☐N Artificial joints
☐Y ☐N Asthma
☐Y ☐N Atopic (allergy prone)
☐Y ☐N Back problems
☐Y ☐N Blood disease
☐Y ☐N Cancer _____
☐Y ☐N Circulatory problems
☐Y ☐N Cortisone treatments
☐Y ☐N Cough, persistent
☐Y ☐N Cough up blood
☐Y ☐N Diabetes
☐Y ☐N Epilepsy
☐Y ☐N Fainting
☐Y ☐N Food allergies
☐Y ☐N Glaucoma
☐Y ☐N Headaches
☐Y ☐N Heart murmur
☐Y ☐N Heart conditions
Describe _____
☐Y ☐N Hemophilia/Abnormal bleeding
☐Y ☐N Hepatitis
☐Y ☐N High/Low blood pressure
☐Y ☐N Jaw pain
☐Y ☐N Kidney disease/malfunction
☐Y ☐N Liver disease
☐Y ☐N Material allergies
(laytex,wool, metal, chemicals, etc.)
☐Y ☐N Mitral valve prolapse
☐Y ☐N Nervous problems
☐Y ☐N Pacemaker/heart surgery
☐Y ☐N Respiratory disease
☐Y ☐N Rheumatic/Scarlet fever
☐Y ☐N Shingles
☐Y ☐N Shortness of breath
☐Y ☐N Spina Bifida
☐Y ☐N Stroke
☐Y ☐N Surgical implant
☐Y ☐N Swelling of feet/ankles
☐Y ☐N Thyroid disease/malfunction
☐Y ☐N Tobacco habit

Is patient currently taking any medications? If yes list all: _____

_____

Does patient have drug allergies? If yes, list all: _____

_____

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Patient Information

Please take a few minutes to fill out this form as completely as you can.
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Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Date of last dental care _____ Date of last x-rays _____

Check (√) yes or no if you have had problems with any of the following:

☐Y ☐N Bad breath	☐Y ☐N Food Collection between teeth	☐Y ☐N Periodontal treatment	☐Y ☐N Sensitivity to sweets
☐Y ☐N Bleeding gums	☐Y ☐N Grinding or clenching teeth	☐Y ☐N Sensitivity to cold	☐Y ☐N Sensitivity when biting
☐Y ☐N Clicking or popping jaw	☐Y ☐N Loose teeth or broken fillings	☐Y ☐N Sensitivity to hot	☐Y ☐N Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____ Are you dissatisfied? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐Y ☐N

Other information about your dental health or previous treatment _____

	Yes	No
Do you avoid any part of the mouth while brushing? If yes, where?	☐	☐
Beyond your insurance benefits, are you concerned about finances required to keep or return your teeth to excellent health?	☐	☐
Do you get frustrated that you always have something to be treated or repaired when you visit a dentist?	☐	☐
Have you ever had any teeth removed?	☐	☐
Do you feel you will eventually wear dentures?	☐	☐
Do you have any dental fears?	☐	☐
Did you leave your last dentist? If yes, why?	☐	☐
What have other dentists done for you that you have liked? Explain:	☐	☐
Do you have any of the following problems of the jaw: Pain in jaw or jaw joint ☐Right ☐Left ☐Both Popping clicking or grating in jaw joint ☐Right ☐Left ☐Both	☐	☐
Jaw ever lock-open or shut Headaches ☐Yes ☐No Where: _____ Ear pain ☐Yes ☐No Neck pain ☐Yes ☐No Swallowing difficulties ☐Yes ☐No	☐	☐
Do you clench or grind your teeth?	☐	☐
Any past treatment for TMJ?	☐	☐

Release

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize Fox View Dental to publish the photographs taken of me, and my name, for use in any Fox View Dental printed publications and website. I acknowledge that since my participation in publications and websites produced by Fox View Dental is voluntary, I will receive no financial compensation. I further agree that my participation in any publication and website produced by fox View Dental confers upon me no rights of ownership whatsoever. I release Fox View Dental, its contractors and its employees from liability for any claims by me or any third party in connection with my participation.

Signature _____ Date _____

Payment is due at time of treatment, unless prior arrangements have been approved.