Welcome to Babcock Dental Center

In order to help us serve your dental needs, we need to obtain a thorough health history. Please complete this form to the best of your knowledge and write down any medical conditions, medications (including supplements), and any allergies you have. We look forward to taking care of your oral health!

Patient Information (Please print)

Patient name: _____

Date of Birth: _____

Address: _____

Today's Date: _____

Home Phone: _____

Cell Phone: _____

Social Security #: _____

Who can we thank for referring you? _____

Insurance Information

Employer: _____

Business Phone: _____

Insurance Co: _____

Insurance Address: _____

Insurance Subscriber: _____

Subscriber Soc. Sec. #: _____

Subscriber Birthdate: _____

Group #: _____

Emergency Contact

Name: _____

Relationship:_____

Phone Number:_____

Do we have permission to share information with this person?

YES NO

Physician Information

Physician Name: _____

Office Phone: _____

Date of Last Exam: _____

Are you being seen by any specialist physicians? (cardiologist, endocrinologist, etc.) Please name: _____

Medical History:

Please indicate if you have any of the following, and if so, please explain.

- ▢ Are you pregnant or think you may be pregnant?
- ▢ Are you nursing?
- ▢ Are you taking Birth Control Pills?
- ▢ Do you have PCOS?

- ▢ Are you under any current medical treatment?
- ▢ Have you ever been hospitalized?
- ▢ Have you had surgery in the past?
- ▢ Do you smoke?
  - ★ #packs/day _____
  - ★ # years _____
- ▢ Have you ever smoked?
- ▢ Do you use chewing tobacco or snuff?
- ▢ Do you take aspirin or blood thinners?
- ▢ Have you ever had a reaction to local anesthesia?

- ▢ Arthritis
- ▢ Prior bisphosphonate use
- ▢ Joint Replacement
  - ★ Has your orthopedic surgeon ever advised you to take antibiotics before dental treatment?

- ▢ Respiratory Problems
- ▢ Asthma
- ▢ Emphysema
- ▢ Seasonal Allergies
- ▢ Sleep Apnea
- ▢ COPD or Emphysema

- ▢ High Blood Pressure
- ▢ Heart Disease
- ▢ Heart Attack
- ▢ Heart Murmur
- ▢ Mitral Valve Prolapse
- ▢ Angina/Chest Pain
- ▢ History of Stroke
- ▢ Heart Valve Replacement
- ▢ Cardiac Pacemaker

- ▢ Fainting
- ▢ Epilepsy/Seizures
- ▢ Autoimmune Disease
- ▢ Glaucoma
- ▢ Thyroid Problem (Indicate)
- ▢ Alzheimers/Dementia
- ▢ Hearing Impaired
- ▢ Blindness

▢ Blood Disease ▢ Leukemia ▢ Anemia ▢ Stroke	▢ Tuberculosis ▢ Sexually Transmitted Infection ▢ HIV or AIDS	▢ Anxiety ▢ Depression ▢ Substance Use Disorder ▢ Alcoholism ▢ Other mental health conditions not listed:
▢ Cancer (Indicate type) ▢ Radiation Therapy ▢ Chemotherapy ★ Have you ever been given the chemotherapy drug Zometa?	▢ Liver Disease ▢ Hepatitis/Jaundice ▢ Kidney Disease ▢ Diabetes (Indicate Type 1 or Type 2) ▢ Stomach Ulcers ▢ Stomach Problems ▢ GERD	▢ Are you allergic to Penicillin? ▢ Do you have allergies to any other medications? Please List: _____ _____ _____ _____

Please list any other medical conditions that are not listed above: _____

Please list any prescription or non-prescription medications that you are currently taking. Do not leave any medications unreported.

_____

_____

Dental History:

When was your last dental cleaning? _____

When were your last dental x-rays? _____

Have you ever had difficult dental experiences in the past? _____

- ☐ Have you ever had any head, neck or jaw injuries?
- ☐ Have you had problems with your jaw in the past? (Clicking, pain, difficulty opening/closing, difficulty chewing)
- ☐ Do you have frequent headaches or migraines?
- ☐ Do you feel as though you clench and grind?
- ☐ Are you currently having any pain?
- ☐ Are your teeth sensitive to sweet, hot, or cold?
- ☐ Do your gums bleed while brushing or flossing?
- ☐ Have you ever been diagnosed with gum disease?
- ☐ Have you had braces in the past?
- ☐ Have you ever had prolonged bleeding following extractions?
- ☐ Do you suffer from dry mouth?
- ☐ Are you fearful of dental injections/dental treatment?

Smile Assessment:

- ☐ Are you concerned about the appearance of your teeth or smile?
- ☐ Are you concerned about the whiteness or lack of whiteness of your teeth?
- ☐ Are you concerned about the angle, position, or shape of one or more of your teeth?
- ☐ Are you embarrassed by your teeth or smile?
- ☐ Is your bite uncomfortable when biting or chewing?
- ☐ Are you interested in learning more about esthetic dentistry?
- ☐ Do you have any additional concerns that were not addressed on this form? If yes, please list: _____

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____ _____

Patient, Parent or Guardian Date