

Eastpoint Family Dentistry

1010 S. Northpoint Rd., Baltimore, MD 21224 (410) 282-5561

PATIENT INFORMATION

Name _____ Date _____
Last First M Married Single Minor Male Female
Address _____
Street Apt # City State Zip
Birth Date _____ Age _____ SS# _____
Telephone _____ Cell _____ Email _____
Place of Employment _____ Phone _____
If Full-time Student, School Name _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____
Name of person or office referring you to our practice _____

INSURANCE INFORMATION

Primary
Name of Insured _____ Is insured a patient? Yes No
Insured's Birth Date _____ SS# _____ Group # _____
Insured's Address _____
Street Apt # City State Zip
Insured's Employer's Name _____
Address _____
Street City State Zip
Patient's relationship to insured: Self Spouse Child Other
Insurance Plan Name and Address _____

AUTHORIZATION (All Patients or Guardians must sign)

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or credit information. I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

Patient's or Guardian's Signature Date _____

MEDICAL HISTORY

Are you under a physician's care now? Why? Who? _____ Phone _____ Yes No
 Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
 Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
 Are you taking any medications, pills or drugs? What? _____ Yes No
 Are you allergic to any medications or substances? Please check box below
 Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other
 Women (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives Discuss Yes No

* If yes to any of the starred conditions, please call prior to your appointment...Premedication may be required

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hemophillia (bleeding problem)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur*	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve*	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery*	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joint	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Treatments (Radiation)	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone/Steroid Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint*	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant*	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Pollen/Dust)	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>				Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>						

Have you ever had any illness not checked above? Yes ___ No ___ Discuss _____
 Do you smoke? Yes ___ No ___ How many packs / day? _____
 Do you use any other form of tobacco? Yes ___ No ___ What kind? _____
 Number of sodas or sweet drinks per day? _____
 Do you wish to talk to the dentist privately about any problems? Yes ___ No ___ Discuss _____
 To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
Patient Signature
 Reviewed by Doctor _____ Date _____ BP _____

DENTAL HISTORY

Are any family members current patients? Yes No
 Name of previous dentist _____
 Date of last dental visit _____
 How long since last cleaning? _____
 Reason for changing _____
 Describe your current dental problem _____

APPREHENSION

Do you experience fear of having dental treatment performed? Yes No
 Anything specific? _____
 Do you dread the numbing after effects? Yes No
 Have you had any unpleasant dental experiences? Yes No
 Have you ever received laughing gas in a dental office? Yes No
 Have you ever received any other kind of sedation for treatment? Yes No
 Do you feel you need any help overcoming fear? Yes No

TEETH PROBLEMS

Are your teeth sensitive to hot, cold, sweets or pressure? Yes No
 Does food regularly wedge between certain teeth? Yes No
 Do you have any areas that are hard to floss? Yes No

YOUR SMILE

Do you think you have a pretty smile? Yes No
 Are your teeth crooked? Yes No If so, does this bother you? Yes No
 Have you had any cosmetic dentistry? Yes No
 Do you have any fillings or blemishes on your teeth that look bad? Yes No
 Would you like to have whiter teeth? Yes No
 Is there anything that you feel could make your smile look better?

HEADACHES AND FACIAL PAIN

Do you have frequent headaches? Yes No
 Do you experience popping or clicking upon opening or closing? Yes No
 Do your jaw or facial muscles ever get tired or sore after chewing, sleeping, stress, etc? Yes No
 Do you experience facial muscle pain while chewing or when you wake up? Yes No

GUM PROBLEMS

Do your gums ever bleed when you brush or floss? Yes No
 Have your gums receded or pulled away from your teeth? Yes No
 Do you have bad breath or bad tastes? Yes No