Welcome to Patten Family Dentistry		
ABOUT YOU	2 INSURANCES	
<form></form>	Dental Coverage? Yes   Insurance Co. Name:   Insurance Co. Address:   Insurance Co. Phone #: ()   Group # (Plan, Local, or Policy #):   Insured's Name:   Pental Coverage?   Relation:   Insured's Address:   Secondary Insurance   Dental Coverage?   Yes   NO   Insurance Co. Name:   Insurance Co. Address:   Insurance Co. Name:   Insurance Co. Phone#:   Insurance Co. Phone#:   Insurance Co. Phone#:   Insurance Co. Phone#:   Insurance Co. Phone#:	
By a constraint of the second straint of the second str	Insured's Name:	

## CONTINUED ON BACK

MEDICAL HISTORY

Do you have a personal physician?	Yes 🗆 No
Physician's Name:	
Phone #:	
Your Current Physical Health is Do you smoke or use tobacco in an Have you had any metal rods, pins Are you taking any prescription / o counter or herbal supplemental dr Please list each one:	y other form? ☐ Yes ☐ No or implants? ☐ Yes ☐ No over- the-
Have you ever taken Fosamax, or a Bisphosphonate Have you been told that you snore your breath while sleeping or wak for breath?	☐ Yes ☐ No or hold
Are you currently taking a blood thinn	
OR WOMEN: Ire you using a prescribed method o Ire you pregnant? □ Yes □ No Ire you nursing? □ Yes □ No	
<ul> <li>Y N Abnormal bleeding</li> <li>Y N Alcohol / Drug Abuse</li> <li>Y N Anemia</li> <li>Y N Arthritis</li> <li>Y N Arthritis</li> <li>Y N Artificial bones / Joints/ Valves</li> <li>Y N Asthma</li> <li>Y N Blood Transfusion</li> <li>Y N Blood Transfusion</li> <li>Y N Cancer/ Chemotherapy</li> <li>Y N Colitis</li> <li>Y N Colitis</li> <li>Y N Congenital Heart Defect</li> <li>Y N Diabetes</li> <li>Y N Difficulty Breathing</li> <li>Y N Epilepsy</li> <li>Y N Fainting Spells</li> <li>Y N Frequent Headaches</li> <li>Y N Glaucoma</li> <li>Y N Hay Fever</li> <li>Y N Heart Attack</li> <li>Y N Heart Surgery</li> <li>Y N Hemophilia</li> <li>Y N Hepatitis</li> </ul>	<ul> <li>Y N Herpes / Fever Blisters</li> <li>Y N High Blood Pressure</li> <li>Y N HiV<sup>+</sup> / AIDS</li> <li>Y N Hospitalized for any reason</li> <li>Y N Kidney Problems</li> <li>Y N Liver Disease</li> <li>Y N Low Blood Pressure</li> <li>Y N Mitral Valve Prolapse</li> <li>Y N Mitral Valve Prolapse</li> <li>Y N Osteoporosis / Paget's Disease</li> <li>Y N Pacemaker</li> <li>Y N Pacemaker</li> <li>Y N Radiation Treatment</li> <li>Y N Radiation Treatment</li> <li>Y N Rehumatic / Scarlet Fever</li> <li>Y N Seizures</li> <li>Y N Sickle Cell Disease / Traits</li> <li>Y N Sinus Problems</li> <li>Y N Stroke</li> <li>Y N Tuberculosis (TB)</li> <li>Y N Ulcers</li> </ul>
Please List any serious medical conditi Are you Allergic to any of the fol Aspirin Erythr Codeine Latex	l <b>lowing?</b> romycin Tetracycline

Please list current medications:\_\_\_\_



DENTAL HISTORY

Why have you come to the dentist today?

Dental treatment? Are you currently in pain?	🗆 Yes	
		□ No
Harro more had againer	🗆 Yes	🗆 No
Have you had serious problems		
associated with dental work?	🗆 Yes	□ No
Do you have fears about going		
to the dentist?	$\Box$ Yes	
Have you ever had gum treatment?	□ Yes	□ No
Do you now or have you ever		
experienced pain? Discomfort in your		
jaw joint (TMJ/ TMD)?	☐ Yes	110
Your current dental health is $\Box$ Good	_	
Do your gums ever bleed?	□ Yes	
How many times a week do you floss?		
How many times a day do you brush?		
- <b>J F - - - - - - - - - -</b>	ard	ain a
How long do you use a toothbrush befo	ore repla	ung
it? Are your teeth sensitive to hot, cold or	anything	ت مادم؟
Are your teeth sensitive to not, cold of	anytim	3 6156:
Have you lost any teeth?	□Yes	□No
if yes, why?		
Previous Dentist:		
Last Visit Date:		
Last visit butt		
I understand the information that I have		
correct to the best of my knowledge. I that this information will be held in the confidence and it is my responsibility to office of any changes in my medical stat the dental staff to perform any necessa that I may need during diagnosis and t informed consent.	also unde e strictes to inform atus. I aut ary denta	erstand t of this horize l services