BLUE DIAMOND DENTAL, P.A.

Patient Information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information on this form is important to your dental health.

Patient Name:_____Date of Birth:_____ Sex:_____Age:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____Email:_____

SS#:_____ Employer/Occupation:_____ Phone:_____

Emergency Contact & Phone:_____

Primary dental insurance:_____ Group #_____

Secondary dental insurance:_____Group # _____

Subscribers name:_____Date of Birth:_____ SS#:_____

Name of your Medical doctor:_____Date of last visit:_____

Name of previous dentist:_____ Date of last visit:_____

Dental Health

Are you apprehensive about dental visits? □Yes □No
Have you had problems with previous dental treatments? □Yes □No
Do you gag easily? □Yes □No
Do you wear dentures/partials? □Yes □No
Does food catch between your teeth? □Yes □No
Do you have difficulty chewing food? □Yes □No
Do your gums bleed easily? □Yes □No
Do you have a history of cold sores/fever blisters? □Yes □No
Is your mouth dry? □Yes □No
Have you had periodontal (gum) treatments? □Yes □No

Are you Allergic, or have reacted adversely, to any of the following?

Local anesthetics □Yes □No
Penicillin/ other antibiotics □Yes □No
Sulfa drugs □Yes □No
Aspirin, Acetaminophen, or Ibuprofen □Yes □No
Codiene, Demerol, or other Narcotic □Yes □No
Latex □Yes □No
NSAID(Celebrex, Vioxx,Anaprox) □Yes □No
Clindamycin □Yes □No
Iodine □Yes □No
Other_____

Are your teeth sensitive? □Yes □No
Do you feel twinges of pain when your teeth come in contact with:

- Hot foods or liquids? □Yes □No
- Cold foods or liquids? □Yes □No
- Sweet? □Yes □No

Do you take Fluoride supplements? □Yes □No
Are you unhappy with the appearance of your teeth? □Yes □No
Do you clench or grind your teeth or jaw frequently? □Yes □No
Do you have temporomandibular (jaw) disorder? □Yes □No

Do you or the patient have any of the following:

Learning Disabilities □Yes □No
If yes, explain:_____
Emotional/Psychological Disabilities □Yes □No
If yes, explain:_____
Hearing/Speech Difficulty □Yes □No
If yes, explain:_____
Eating Disorder □Yes □No
If yes, explain:_____
Developmental Disability or Delay □Yes □No
If yes, explain:_____
Special Needs/Behavioral (Autism, ADHD, ADD, etc.) □Yes □No
If yes, explain:_____