MEREDITH GOODRICH, DMD
Family & Cosmetic Dentistry

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. We respect your privacy. In accordance with HIPAA, a copy of our privacy practices is available on request.

Name _____ I prefer to be called _____

Street Address _____ Email _____

City _____ State _____ Zip _____

Home phone _____ Cell _____ Work _____

Employer _____ Occupation/Hobby _____

Date of Birth: _____/_____/_____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Divorced Spouse's name: _____

Closest Relative _____ Phone: _____

Name of your medical doctor _____ Date of last visit to medical doctor _____

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

Who were you referred by? _____

Dental Health History

YES	NO		YES	NO	
☐	☐	Are you apprehensive about dental treatment?	☐	☐	Have you had a blow to the jaw (trauma)?
☐	☐	Do you have any dental problems: food packing, tooth pain, bleeding gums, cold sores, or the like?	☐	☐	Have you ever noticed slow-healing sores, bumps, red /white spots in your mouth or throat?
☐	☐	Have you had problems with previous dental treatment?	☐	☐	Do you have a temperomandibular (jaw) disorder (TMD)?
☐	☐	Are you interested in cosmetic smile changes such as whitening, veneers, orthodontics?	☐	☐	Do you have pain in the face, cheeks, jaws, joints, throat, or temples?
☐	☐	Are your teeth sensitive to cold or sweets?	☐	☐	Do you clench or grind your jaws frequently?
☐	☐	Do you frequently snore?	☐	☐	Are you aware of an uncomfortable bite?
☐	☐	Are you a habitual gum chewer or pipe smoker?			How often do you brush? _____
☐	☐	Do you use an electric toothbrush? _____			How often do you floss? _____

Do you have any concerns you would like to discuss today? What would you like for your teeth and smile? _____

_____

General Health History

I. HAVE YOU EXPERIENCED:

YES	NO		YES	NO	
☐	☐	Chest pain (angina)?	☐	☐	Dizziness?
☐	☐	Swollen ankles?	☐	☐	Ringing in ears?
☐	☐	Shortness of breath?	☐	☐	Headaches?
☐	☐	Recent weight loss, fever, night sweats?	☐	☐	Fainting spells?
☐	☐	Persistent cough, coughing up blood?	☐	☐	Blurred vision?
☐	☐	Bleeding problems, bruising easily?	☐	☐	Seizures?
☐	☐	Sinus problems?	☐	☐	Excessive thirst?
☐	☐	Difficulty swallowing?	☐	☐	Frequent urination?
☐	☐	Chronic diarrhea, constipation, blood in stools?	☐	☐	Dry mouth?
☐	☐	Frequent vomiting, nausea?	☐	☐	Jaundice?
☐	☐	Difficulty urinating, blood in urine?	☐	☐	Joint pain, stiffness?

II. DO YOU HAVE OR HAVE YOU HAD:

YES	NO		YES	NO	
☐	☐	Heart disease?	☐	☐	Stomach problems, ulcers?
☐	☐	Heart attack, heart defects?	☐	☐	HIV/AIDS
☐	☐	Heart murmurs?	☐	☐	Tumors, cancer?
☐	☐	Pacemaker?	☐	☐	Gardasil vaccination?
☐	☐	Rheumatic fever?	☐	☐	Arthritis, rheumatism?
☐	☐	Stroke, hardening of arteries?	☐	☐	Eye diseases?
☐	☐	High blood pressure?	☐	☐	Skin diseases?
☐	☐	Asthma, TB, emphysema, other lung diseases?	☐	☐	Anemia?
☐	☐	Hepatitis, other liver disease?	☐	☐	Herpes, fever blisters?
☐	☐	Family history of diabetes, heart problems, cancer?	☐	☐	Kidney, bladder disease?
☐	☐	Psychiatric care?	☐	☐	Thyroid, adrenal disease?
☐	☐	Radiation treatments?	☐	☐	Diabetes?
☐	☐	Chemotherapy?	☐	☐	Hospitalization?
☐	☐	Prosthetic heart valve?	☐	☐	Blood transfusions?
☐	☐	Artificial joint, knee, hip?	☐	☐	Surgeries?
☐	☐	Allergies to: drugs, foods, medications, latex, metal?	☐	☐	Osteoporosis?
		List: _____	☐	☐	Bisphosponates?

III. WOMEN ONLY:

Are you or could you be pregnant or nursing? _____ Taking birth control pills?_____

IV. ALL PATIENTS:

1. Has there been a change in your health within the last year? _____
2. Have you been hospitalized or had a serious illness in the last three years?

   If YES, why?_____
3. Do you drink alcohol? How much and how often? Red wine? _____
4. Have you used tobacco in any form? How much and for how long? _____
5. Have you used recreational drugs? _____
6. Have you had any other diseases or medical problems NOT listed on this form?

   If so, please explain:_____

   _____
7. Are you taking any medications, vitamins or supplements? If YES, please list: _____

_____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____Date:_____

For completion by the dentist:

Date _____Signature of Dentist _____ Pt B/P _____

Comments on patient interview concerning medical history _____

_____

_____

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