DURAN DENTAL CENTER, INC.

ADULT PATIENT INFORMATION

Please complete this form so we can provide safe, personalized dental care.

1 Patient Information

Patient Name

Today's Date

Home Address

Date of Birth

Business Address

Home Phone

Business Phone

Social Security No.

2 Medical Care

Physician

Office Phone

Date of Last Exam

Are you under medical treatment now?	Yes	No
Have you ever been hospitalized for any surgical operation or serious illness?	Yes	No
Are you taking any medication(s), including non-prescription medicine?	Yes	No
Do you use tobacco?	Yes	No
Do you use alcohol, cocaine or other drugs?	Yes	No
Are you wearing contact lenses?	Yes	No

If yes, what medication(s) are you taking?

3 Allergies / Reactions

Are you allergic to or have you had any reactions to the following?

Local anesthetics (e.g. novocaine)	Barbiturates	Aspirin
Penicillin or other antibiotics	Sedatives	Other

4 Medical History

Do you have or have you had any of the following? Check Yes or No.

High Blood Pressure	Y	N	Heart Disease	Y	N	Chest Pains	Y	N
Heart Attack	Y	N	Cardiac Pacemaker	Y	N	Easily Winded	Y	N
Rheumatic Fever	Y	N	Heart Murmur	Y	N	Stroke	Y	N
Swollen Ankles	Y	N	Angina	Y	N	Hay Fever / Allergies	Y	N
Fainting / Seizures	Y	N	Frequently Tired	Y	N	Tuberculosis	Y	N
Asthma	Y	N	Anemia	Y	N	Radiation Therapy	Y	N
Low Blood Pressure	Y	N	Emphysema	Y	N	Glaucoma	Y	N
Epilepsy / Convulsions	Y	N	Cancer	Y	N	Recent Weight Loss	Y	N
Leukemia	Y	N	Arthritis	Y	N	Liver Disease	Y	N
Diabetes	Y	N	Joint Replacement or Implant	Y	N	Heart Trouble	Y	N
Kidney Diseases	Y	N	Hepatitis / Jaundice	Y	N	Respiratory Problems	Y	N
AIDS or HIV Infection	Y	N	Sexually Transmitted Disease	Y	N	Other	Y	N
Thyroid Problem	Y	N	Stomach Troubles / Ulcers	Y	N			

If Other, please describe

5 Additional Medical Information

Women only:

Are you pregnant or think you may be pregnant?	Yes	No
Are you nursing?	Yes	No
Are you taking birth control pills?	Yes	No

Comments / additional medical information

6 Patient Dental History

Do your gums bleed while brushing or flossing?	Yes	No
Are your teeth sensitive to hot or cold liquids/foods?	Yes	No
Are your teeth sensitive to sweet or sour liquids/foods?	Yes	No
Do you feel pain to any of your teeth?	Yes	No
Do you have any sores or lumps in or near your mouth?	Yes	No
Have you had any head, neck or jaw injuries?	Yes	No
Have you experienced clicking in your jaw?	Yes	No
Have you experienced pain in the jaw joint, ear or side of face?	Yes	No
Do you have difficulty opening or closing your mouth?	Yes	No
Do you have difficulty chewing?	Yes	No
Do you have frequent headaches?	Yes	No
Do you clench or grind your teeth?	Yes	No
Do you bite your lips or cheeks frequently?	Yes	No
Have you ever had any difficult extractions in the past?	Yes	No
Have you had any orthodontic work?	Yes	No
Have you ever had prolonged bleeding following extractions?	Yes	No
Have you ever had instruction on the correct method of brushing your teeth?	Yes	No
Have you ever had instructions on the care of your gums?	Yes	No

7 Certification & Authorization

I certify that I have read and understand the information above. To the best of my knowledge, the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I will notify Duran Dental Center, Inc. of any changes in my health or medications.

Signature of Patient / Parent / Guardian

Date

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