MARK J. ANDREWS DDS PA
COSMETIC & GENERAL DENTISTRY

PATIENT INFORMATION

Date____

Name____ Spouse's Name_______________________________

Address____ State __________ Zip ____________

Home Phone ________________________ Work ________________________ Mobile__________________________

Email ____

Date of Birth ________________________ Sex _____________ Height ______________ Weight________________

Occupation ____ Single_________ Married _________

Closest Relative ____ Phone __________________________________

Whom may we thank for referring you to us? ____

MEDICAL HEALTH

Name and Address of Physician ____

Have you been under a physician's care during the past 2 years? ______ For ______________________________

Have you been treated in a hospital in the past 2 years? ______ For ______________________________________

Have you ever had major surgery? ____

If female: Are you taking hormones or birth control? ________ Are you pregnant or nursing? ________________

Have you ever had a blood test for hepatitis? __________ Were you vaccinated? ___________________________

Have you had cankers or cold sores on your lips, tongue, gums or body?__________________________________

Are you now taking or have you taken any prescription drugs during the past year?________ For ____________

____

Are you allergic to? ❑ Penicillin ❑ Codeine ❑ Local Anesthetics ❑ Latex

Other ____

HAVE YOU HAD OR DO YOU NOW HAVE:

Abnormal Blood Pressure.................................... Yes/No
AIDS .... Yes/No
Allergies.. Yes/No
Anemia .... Yes/No
Angina .... Yes/No
Arthritis.. Yes/No
Artificial Heart Valves.. Yes/No
Artificial Joints .... Yes/No
Asthma.. Yes/No
Cancer .... Yes/No
Chemotherapy .... Yes/No
Congenital Heart Lesions....................................... Yes/No
Diabetes... Yes/No
Drug Dependency... Yes/No
Epilepsy .... Yes/No
Fainting.. Yes/No
Glaucoma .... Yes/No
Heart Disease.. Yes/No
Heart Murmur .... Yes/No

Hepatitis .... Yes/No
Herpes .... Yes/No
Jaundice .... Yes/No
Kidney Disease... Yes/No
Liver Disease... Yes/No
Organ Transplant .... Yes/No
Pacemaker .... Yes/No
Polio .... Yes/No
Prolonged Bleeding .... Yes/No
Prolonged Cough.. Yes/No
Psychiatric Treatment... Yes/No
Radiation Therapy .... Yes/No
Rheumatic Fever... Yes/No
Sickle Cell Anemia .... Yes/No
Stroke .... Yes/No
Thyroid Disease .... Yes/No
Tuberculosis... Yes/No
Ulcers.. Yes/No
Venereal Disease.. Yes/No

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DENTAL HEALTH

What is your major dental concern? (check all that apply)
❑ I need a dental checkup ❑ My teeth hurt ❑ My gums hurt
❑ I don't like the appearance of my teeth or gums ❑ I have some teeth that are chipped or broken
Other (please explain) ____

How long ago was your last dental checkup and/or cleaning? (check all that apply)
❑ Less than 1 year ago ❑ 1-2 years ❑ More than 2 years ❑ I've never had a dental checkup and/or cleaning

How often do you use dental floss?
❑ More than once a day ❑ Once a day ❑ Once or twice a week ❑ Hardly ever ❑ Never

Do the following things happen often enough to bother you? (check all that apply)
❑ Food or dental floss gets caught between my teeth
❑ Gums bleed or hurt when I brush my teeth
❑ My teeth are sensitive to heat
❑ My teeth are sensitive to cold
❑ My teeth are sensitive to biting
❑ My teeth are sensitive without any stimulus at all
❑ I clench and/or grind my teeth
❑ I have pain or clicking in my jaw joints
❑ I get sores in my mouth
❑ I have bad breath

Which of the following dental treatments have you had? (check all that apply)
❑ Root Canal Therapy
❑ Crowns ("Caps")
❑ Bridges
❑ Removable Dentures
❑ Tooth Extractions
❑ Veneers
❑ Gum Surgery
❑ Dental Implants
❑ Orthodontics
❑ Filling
❑ Sealants

Which Statement best describes your approach to dental care? (check all that apply)
❑ I go to the dentist regularly even if I don't have problems
❑ I don't go to the dentist unless I have a problem
❑ I would like to be more proactive about my dental care than I have been in the past

Have you ever had problems or complications with your previous dental care? Yes/No

Is there anything about dental care that worries you or that you strongly dislike? Yes/No
If Yes, explain ____

Do you have any questions about your teeth, gums or oral health? Yes/No
If Yes, explain ____

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, advise and treatment provided for the purpose of evaluating administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advise and treatment to another dentist. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE ______________________________

DATE ________________