Office Use Only: Patient ID_______

Duluth Dental Center

Patient Information Today's Date: ________

Please Print

First Name: ____________________ Middle: ________________ Last Name: ____________________

Street: ____ City: ______________ Zip: _______

Home Phone: __________________ Cell Phone: ____________________

Email Address: ____

Patient Date of Birth: ____________ Patient SSN: ____________ Sex: (circle) **M F**

Best way to Contact You: (Circle) Home Phone Cell Phone Email Text Best time of day: _________

How did you hear about us? (Circle) Google Friend Family Member Insurance Company Other

Going to the dentist makes me feel: (Circle one) Anxious Afraid OK I love going to the dentist

Insurance Information

Do you have dental Insurance? (Circle) Yes No Do you have Secondary dental Insurance? (Circle) Yes No

Primary Insured		Secondary Insured	
Subscriber Name:		Subscriber Name:	
Subscriber SSN:		Subscriber SSN:	
Date of Birth:		Date of Birth:	
Relationship to Subscriber:		Relationship to Subscriber:	
Employer Name:		Employer Name:	
Employer Phone:		Employer Phone:	
Insurance Company:		Insurance Company:	
Insurance Group #:		Insurance Group #:	
Insurance Phone #:		Insurance Phone #:	

Dental Information (For the following please circle either Y or N)

Do your gums bleed when you brush or floss?	Y/N	Are you currently experiencing dental pain or discomfort?	Y/N
Are your teeth sensitive to cold, hot, sweets or pressure?	Y/N	Were you happy with your last dentist? Please explain.	Y/N

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Is your mouth dry?	Y/N	Do you grind or clench your teeth?	Y/N
Have you had periodontal (gum) treatments?	Y/N	Do you snore?	Y/N
Have you ever had orthodontic (braces) treatment?	Y/N	Do you wear dentures or partials?	Y/N
Have you had any problems associated with previous dental treatment?	Y/N	Have you ever had a serious injury to your head or mouth?	Y/N
If yes, please explain.		Date of Last Dental Exam: Date of Last Dental X-Ray:	

Medical Information

Are you now under the care of a physician? (Circle) Yes/ No

Physician Name: ___________________________________ Physician's Phone Number: _________________

Are you in good health? (Circle) Yes/ No

Has there been any change in your general health within the past year? If yes, please explain.

Have you been hospitalized in the past 5 years? If yes, please explain.

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, or finger) replacement? If yes, please list the date and any complications.

Are you scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? If yes, please explain.

Do you use tobacco (smoking, chew, snuff)? If yes, are you interested in quitting?

Medications: Please list any medications you are currently taking, and why.

1.	6.
2.	7.
3.	8.
4.	9.
5.	10

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Allergies: Please circle either Yes, No or Don't Know. If yes, please specify type of reaction.

Are you allergic to or had a reaction to:				Codeine or other Narcotics	Y	N	DK
Local anesthetic	Y	N	DK	Metals	Y	N	DK
Aspirin	Y	N	DK	Latex (Rubber)	Y	N	DK
Penicillin	Y	N	DK	Iodine	Y	N	DK
Barbiturates, Sedatives, or sleeping pills	Y	N	DK	Food	Y	N	DK
Sulfa Drugs	Y	N	DK	Other	Y	N	DK

WOMEN ONLY			
Are you pregnant? If yes, number of weeks:_________________	Y	N	DK
Are you taking birth control pills or hormonal replacement?	Y	N	DK
Are you nursing?	Y	N	DK

Please circle your response to indicate if you have or have not had any of the following diseases or problems

Artificial (Prosthetic) Heart Valve					Y	N	DK
Previous Infective Endocarditis					Y	N	DK
Damaged Valves in Transplanted Heart					Y	N	DK
Congenital Heart Disease (CHD)							
- Unrepaired cyanotic CHD					Y	N	DK
- Repaired (completely) in last 6 months					Y	N	DK
- Repaired CHD with residual defects					Y	N	DK
Cardiovascular Disease	Y	N	DK	**Cancer/Chemotherapy/Radiation**	Y	N	DK
Angina	Y	N	DK	Chest Pain Upon Exertion	Y	N	DK
Arteriosclerosis	Y	N	DK	Chronic Pain	Y	N	DK
Congestive Heart Failure	Y	N	DK	**Diabetes Type I**	Y	N	DK
Damaged Heart Valves	Y	N	DK	**Diabetes Type II**	Y	N	DK
Heart Attack	Y	N	DK	Eating Disorder	Y	N	DK
Heart Murmur	Y	N	DK	Malnutrition	Y	N	DK

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Low Blood Pressure	Y	N	DK	Gastrointestinal Disease	Y	N	DK
High Blood Pressure	Y	N	DK	G.E. Reflux/ Persistent Heartburn	Y	N	DK
Other Congenital Heart Defects	Y	N	DK	Ulcers	Y	N	DK
Mitral Valve Prolapse	Y	N	DK	Thyroid Problems	Y	N	DK
Pacemaker	Y	N	DK	**Stroke**	Y	N	DK
Rheumatic Fever	Y	N	DK	Glaucoma	Y	N	DK
Abnormal Bleeding	Y	N	DK	Hepatitis, Jaundice, or liver disease	Y	N	DK
Anemia	Y	N	DK	**Epilepsy**	Y	N	DK
Blood Transfusion if yes, date:______	Y	N	DK	**Fainting Spells or Seizures**	Y	N	DK
Hemophilia	Y	N	DK	**Neurological Disorders**	Y	N	DK
AIDS or HIV infection	Y	N	DK	Sleep Disorders	Y	N	DK
Arthritis	Y	N	DK	Mental Health Disorder	Y	N	DK
Autoimmune Disease	Y	N	DK	Recurrent Infections	Y	N	DK
Rheumatoid Arthritis	Y	N	DK	Kidney Problems	Y	N	DK
Systemic Lupus Erythematosus	Y	N	DK	Osteoporosis	Y	N	DK
Asthma	Y	N	DK	Persistent Swollen Glands	Y	N	DK
Bronchitis	Y	N	DK	Severe Headaches/ Migraines	Y	N	DK
Emphysema	Y	N	DK	Sexually Transmitted Disease	Y	N	DK
Sinus Trouble	Y	N	DK	**Tuberculosis**	Y	N	DK

Doctor Use Only:

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