Brent L. Blaylock, D.D.S., P.A.

Welcome to our office!

Thank you for taking the time to answer these questions thoroughly and accurately. If you have questions, please ask.

Name: _____ Today's date: _____

Social Security Number: _____ Date of Birth: _____ Spouse: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

How do you prefer that we contact you? (Please rank 1, 2, 3) Home phone: _____ Cell phone: _____ Email: _____

Occupation: _____ Business Name: _____

Business Address: _____ Phone: _____

Person to contact in case of emergency: _____ Phone: _____

Physician's Name: _____ Phone: _____

Dental Insurance Company: _____ Subscriber ID: _____

Person responsible for account: _____ Phone: _____

Please list other family members treated in this office: _____

Whom may we thank for referring you? _____

Do you have any hobbies or special interests? _____

Dental History

1. How can we help you today? What would you like us to do for you? _____
2. Do you have any discomfort in your mouth presently? Explain: _____
3. When was your last dental visit? _____ What was done? _____
4. When and where were x-rays of your teeth last taken? _____
5. Do your gums bleed when you brush or floss your teeth? ..... ❑ Yes ❑ No
6. Have you ever been told you have periodontal or gum disease? ..... ❑ Yes ❑ No
7. Are your teeth sensitive to heat, cold, sweets, or chewing? ..... ❑ Yes ❑ No
8. Do you have any sensitivity to dental anesthetics? ..... ❑ Yes ❑ No
9. Do you feel nervous about having dental treatment? ..... ❑ Yes ❑ No
10. Do you get frequent blisters or ulcers on your lips or in your mouth? ..... ❑ Yes ❑ No
11. Have you ever been diagnosed with a problem in either jaw joint? ..... ❑ Yes ❑ No
12. Does your jaw click, pop, or make noise when you open and close your mouth? ..... ❑ Yes ❑ No
13. Do you have pain or tenderness in your jaw when you open, close, or chew? ..... ❑ Yes ❑ No
14. Has your jaw ever locked open or closed? ..... ❑ Yes ❑ No
15. Do you have frequent headaches? ..... ❑ Yes ❑ No
16. Do you clench or grind your teeth, or have been told that you do? ..... ❑ Yes ❑ No
17. Do you have a history of trauma to your chin or jaw? ..... ❑ Yes ❑ No
18. How do you feel about your teeth, smile and bite? If you could, what would you change? _____

_____

Medical History

1. Are you allergic to (i.e., itching, rash, swelling of hands, feet, eyes, tongue) or made sick by: (Please Check)
   ❑ Penicillin, ❑ Sulfa, ❑ Aspirin, ❑ Ibuprofen, ❑ Codeine, Other (Please List) _____
2. Please list any medications you are currently taking or have taken in the past two years: _____
   _____
3. Have you been hospitalized for any surgery or serious illness in the last two years?.....❑ Yes ❑ No
   Please Explain: _____
4. Have you been under the care of a medical doctor in the last two years?.....❑ Yes ❑ No
5. Have you ever had any excessive bleeding requiring special treatment?.....❑ Yes ❑ No
6. Do you take Coumadin, Warfarin, Aspirin or any other anticoagulant (blood thinner)?.....❑ Yes ❑ No
7. Have you traveled outside the United States in the last two months?.....❑ Yes ❑ No
8. Have you ever been treated for cancer or a tumor? Please Explain: .....❑ Yes ❑ No
9. Have you ever been told you need to take antibiotics prior to dental treatment?.....❑ Yes ❑ No
10. Check any of the following that you currently have or have had:

❑ Heart Disease or Attack	❑ Blood Transfusion	❑ Diabetes
❑ Chest Pains or Angina	❑ Anemia	❑ Allergies or Hives
❑ High Blood Pressure	❑ Sickle Cell Disease	❑ Sinus Trouble
❑ Heart Murmur	❑ Bruise Easily	❑ Thyroid Disease
❑ Congenital Heart Defect	❑ Hemophilia	❑ Radiation Treatment
❑ Heart Valve Replacement	❑ AIDS/HIV Positive	❑ Chemotherapy
❑ Mitral Valve Prolapse	❑ Hepatitis A, B, or C	❑ Arthritis
❑ Scarlet or Rheumatic Fever	❑ Liver Disease or Yellow Jaundice	❑ Rheumatism
❑ Heart Pacemaker	❑ Drug/Alcohol Dependency	❑ Osteoporosis
❑ Atrial Fibrillation	❑ Sexually Transmitted Disease (STD)	❑ Bisphosphonate Therapy
❑ Irregular Heart Beat	❑ Herpes	❑ Human Papilloma Virus (HPV)
❑ Heart Surgery	❑ Epilepsy or Seizures	❑ Dry Mouth
❑ Stroke/ TIA	❑ Fainting or Dizzy Spells	❑ Ulcers
❑ Emphysema or COPD	❑ Nervousness/Anxiety	❑ Gastric Reflux/GERD
❑ Persistent Cough	❑ Psychiatric Treatment	❑ Dementia/Alzheimer's disease
❑ Tuberculosis (TB)	❑ Shingles	❑ Kidney Problems
❑ Asthma	❑ Joint Replacement	❑ Sjögren Syndrome
❑ Sleep Apnea	❑ Migraines	❑ Dry Mouth
❑ Unexplained Weight Loss/Gain	❑ Leukemia	❑ Wear a Mouth Guard at Night

11. Please list any disease, condition or problem not listed above: _____
12. Do you smoke or use smokeless tobacco? ..... ❑ Yes ❑ No
13. Do you experience chest pain, shortness of breath, or fatigue with walking or climbing stairs?.....❑ Yes ❑ No
14. Do your ankles swell during the day? .....❑ Yes ❑ No
15. Are you on a special diet? .....❑ Yes ❑ No
16. Do you wake up from sleep short of breath?..... ❑ Yes ❑ No
17. WOMEN: Are you pregnant or anticipate becoming pregnant in the near future?.....❑ Yes ❑ No
    Are you taking oral contraceptives?.....❑ Yes ❑ No

I understand that the information provided on this form is essential to determine proper treatment of my dental needs. I understand that any changes in my health need to be reported to the dental office as soon as possible. I have read and understood each question and have answered all questions truthfully and to the best of my ability. I agree not to hold my dentist or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

I understand that I am responsible for any fees for professional services that are rendered.

_____ _____

Signature of patient/responsible party Date