Magnolia Springs
DENTISTRY

PATIENT INFORMATION

Today's Date: _____

First Name: _____ Middle Name: _____ Last Name: _____

Name that you prefer to be called: _____

Sex: ☐M ☐F Date of Birth: _____ Social Security Number: _____

Address: _____ City _____State _____ Zip _____

Phone number: (h) _____ (c)_____ (w) _____

Email address: _____

Preferred method of communication: ☐ Phone call ☐ Text message ☐ Email

Marital status: ☐M ☐S ☐W ☐D **Number of children: _____ Children's ages _____**

Are you presently employed? ☐Yes ☐No ☐Full time ☐Part time ☐Unemployed ☐Disabled ☐Retired

Occupation: _____ Employer: _____

What is the reason for seeing us today? _____

Who may we thank for referring you? _____

What can we do to ensure your experience with us is a pleasant one? _____

What was the reason you stopped seeing your previous dentist? _____

SUBSCRIBER EMPLOYMENT INFORMATION

The following is for: ☐ patient ☐ the insurance policy holder
Employer Name:_____ Phone:_____
Address: _____ City _____State _____ Zip _____
Occupation: _____

SPOUSE OR SUBSCRIBER EMPLOYMENT INFORMATION

The following is for: ☐ **patient's spouse** ☐ the insurance policy holder
First Name_____ Middle Name_____ Last Name _____
Name that you prefer to be called: _____
Sex: ☐M ☐F Date of Birth: _____ Social Security Number: _____
Address: _____ City _____State _____ Zip _____
Phone number: (h) _____ (c)_____ (w) _____
Email address: _____

DOCTOR HISTORY

Primary Care or Referring Physician (Name & Phone): _____
Previous Dentist (Name & Phone): _____

EMERGENCY CONTACTS

Emergency Contact (Name & Phone): _____
Emergency Contact (Name & Phone): _____

INSURANCE INFORMATION

Primary Dental Insurance

Insurance Name: _____ Phone #: _____
Subscriber Name: _____ Subscriber ID#: _____
Subscriber Social Security #:_____ Subscriber Date of Birth: _____
Group / Policy Number: _____
Is this an employer or union policy? _____

Secondary Dental Insurance

Insurance Company Name: _____ Phone #_____
Subscriber Name: _____ Subscriber Employer: _____
Subscriber Social Security #:_____ Subscriber Date of Birth: _____
Group / Policy Number: _____
Is this an employer or union policy? _____

Primary Medical Insurance

Insurance Company Name: _____ Phone #_____
Subscriber Name: _____ Subscriber Employer: _____
Subscriber Social Security #:_____ Subscriber Date of Birth: _____
Group / Policy Number: _____
Do you have secondary medical insurance? _____

MEDICAL HISTORY

Patient's Name: _____ **Today's Date: _____**

Date of Last Physical: _____ Weight: _____ Height: _____

Please check if you have ever had any of the following:

- ☐ Allergies (seasonal)
- ☐ Allergies to latex
- ☐ Allergies to medications (list below)
- ☐ Acid Reflux/ GERD
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Angina / Chest pain
- ☐ Anxiety
- ☐ Blood disease
- ☐ Breast Implants
- ☐ Breathing problems
- ☐ Bleeding disorder
- ☐ Chronic bronchitis
- ☐ Chronic fatigue
- ☐ Cancer or tumors
- ☐ Circulation problems
- ☐ Congenital heart condition
- ☐ Diabetes
- ☐ Drug / Alcohol abuse
- ☐ Depression
- ☐ Dizziness
- ☐ Earaches
- ☐ Emphysema
- ☐ Epilepsy / seizures
- ☐ Eating disorder
- ☐ Fainting / dizzy spells
- ☐ Glaucoma
- ☐ Gall bladder problems
- ☐ Herpes
- ☐ Heart disease
- ☐ Heart Valve replacement
- ☐ Head / neck trauma
- ☐ Heart attack
- ☐ Healing problems
- ☐ Headaches
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV / AIDS
- ☐ Immune system disorder
- ☐ Infective endocarditis
- ☐ Jaundice
- ☐ Joint replacement/Prosthetic Joint
- ☐ Kidney disease
- ☐ Joint disease
- ☐ Liver disease
- ☐ Lupus
- ☐ Mitral valve prolapse
- ☐ Neurological problem/disorder
- ☐ Nervous disorders
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Persistent cough
- ☐ Panic attacks
- ☐ Psychiatric care
- ☐ Psychological disorders
- ☐ Pacemaker
- ☐ Radiation therapy
- ☐ Ringing in ears (Tinnitus)
- ☐ Rheumatic fever
- ☐ Rheumatoid arthritis
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ STD
- ☐ Sleep apnea
- ☐ Stomach problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid disorder
- ☐ Ulcers
- ☐ Other _____

Do you have any allergies to medications?

☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Tetracycline

☐ Other allergies to medications (please list): _____

If you checked any of the above or have other medical conditions, please explain: _____

_____

_____

Number of alcoholic drinks per week: _____

Do you or have you ever smoked or used chewing tobacco? ☐ YES ☐NO

If yes, how much and for how long? _____

Do you or have you ever used Cannabis products? ☐ YES ☐NO

If yes, how much and for how long? _____

Have you had a **heart attack or heart surgery (bypass/stent)** in the last 6 months? ☐**Yes** ☐**No Have you ever taken "bisphosphonates"** (Fosamax, Actonel, Aredia, or Pamidronate?) ☐**Yes** ☐**No**

Women Only: Any chance you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐**No**

Please list ALL medications that you are currently taking:

☐ I take no medications at this time

Medication	How often	For What	Amount taken	Doctor

I certify that the above is true to the best of my knowledge. I understand that if there are any changes to my health or medications, I will advise my dentist before beginning any treatment.

Patient **Name: _____ Today's Date: _____**

Patient Signature: _____

DENTAL HISTORY

Patient's Name: _____ Date: _____ Date of last dental exam:_____

Date of last cleaning:_____ How often do you brush? _____ How often do you floss? _____

Please check all that apply to you:

☐ Bleeding gums ☐ Tooth removal ☐ Food gets stuck ☐ Accident in past ☐ Pain when chewing
☐ Tooth decay ☐ Braces ☐ Loose teeth ☐ Gum surgery ☐ Jaw surgery
☐ Broken teeth ☐ Sensitive teeth ☐ Toothache ☐ Bad breath ☐ Hot / cold sensitive
☐ Wear of teeth ☐ Crowding of teeth ☐ Dry mouth ☐ Other: _____

Are you happy with the way your teeth look?☐YES ☐NO If not, why? _____

Are you dissatisfied with any of the following?

☐ Shape of teeth ☐ Crowding ☐ Silver fillings ☐ Color ☐ Length
☐ Spacing ☐ Old fillings ☐ Misalignment ☐ **"Gummy" smile** ☐ Old crowns
☐ Bad bite ☐ Other

Do you have any sores / spots in mouth that haven't healed for more than 2 weeks? ☐ Yes ☐ No

Please check all that apply to you:

☐ TMJ problems ☐ Jaw clicking ☐ Pain in jaw ☐ Grinding teeth
☐ Pain in facial area ☐ Numbness in fingers ☐ Tingling in fingers ☐ Dizziness (vertigo)
☐ Ringing in ears ☐ Numbness in face ☐ Neck or back pain ☐ Jaw clenching
☐ Tightness in face ☐ Wear a night guard ☐ History of jaw lock ☐ Difficulty chewing
☐ Difficulty opening mouth ☐ Pain behind eyes ☐ Trigeminal neuralgia ☐ Bells Palsy

Headache history: please check all that apply to you

Location of pain: ☐ Front of head / forehead ☐ Side of head ☐ Back of head
Intensity of pain: 0 (no pain) 1 2 3 4 5 6 7 8 9 10(extreme pain)
Do you suffer from morning headaches? ☐ Yes ☐ No ☐ Sometimes
Do headaches wake you up from sleep? ☐ Yes ☐ No ☐ Sometimes
Do you have nausea with headaches? ☐ Yes ☐ No ☐ Sometimes
Frequency of headaches: ☐ Constant ☐ Once/day ☐ Once every few days ☐ Once/week

Sleep Apnea Assessment: please check all that apply to you

Have you ever been diagnosed with Sleep Apnea? ☐ Yes ☐ No If yes, when? _____
Diagnosing physician: _____ Name of sleep center? _____
Please check all that apply to you:

☐ Snoring ☐ Gastro-esophageal reflux ☐ Insomnia
☐ Gasping for air during sleep ☐ Feel tired in morning ☐ Poor concentration
☐ Poor memory ☐ Difficulty breathing through nose ☐ Fatigue
☐ Trouble sleeping ☐ Nervousness ☐ Excessive daytime sleepiness
☐ Irritability ☐ Anxiety / depression ☐ Morning stiffness

Have you ever used a CPAP device and could not tolerate it? ☐ Yes ☐ No
If you were not able to tolerate the CPAP, why? _____