HOWARD FAMILY DENTAL

Patient Information

Date:_____ Drivers License #:_____ Pharmacy Name_____ #_____

Name: _____ Nickname: _____ SS#:_____

Date of Birth:_____ Married ☐ Single ☐ Child ☐

Cell Phone #_____ Work #_____ Home #_____

*Emergency Contact _____
Name Phone Number

E-Mail Address: _____
May we contact you by e-mail regarding your appointments and treatment. ☐ Y ☐ N

Street Address: _____ Apt.#: _____

City:_____ State:_____ Zip: _____

Employed By: _____ Since_____

Health Information

Have you had or do you have any of the following? (Please those that apply)

☐ Anemia	☐ Diabetes	☐ Hepatitis A/B/C/D/E/G	☐ Transplant/Prostheses
☐ AIDS (HIV) Positive	☐ Epilepsy	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Arthritis/Rheumatism	☐ Glaucoma	☐ Joint Replacement	☐ Recent Surgeries
☐ Asthma	☐ Heart Disease	☐ Pacemaker	☐ Tuberculosis
☐ Cold Sores	☐ Heart Murmur	☐ Radiation Treatment	☐ Chemical Dependency

Are you presently being treated for any disease, condition or problem not listed? ☐ ☐
If yes please explain: _____

- Name of Physician? _____ Phone: _____
- Are you presently taking any medications, (including birth control)? ☐ Yes ☐ No

  Please list: _____

DO YOU HAVE ANY DRUG ALLERGIES? _____ ☐ **YES** ☐ **NO**

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- Do you have any metal allergies _____ ☐ Yes ☐ No
- Have you ever had any complications or allergic reactions following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you anxious about your appointment? ☐ Yes ☐ No
- Are you pregnant? ☐ Yes ☐ No Due Date:
- Do you currently use any Tobacco products? (Including Vaping) _____ ☐ Yes ☐ No
  If so, how long? _____
- Previous Dentist: _____ Date of last dental visit: _____
- Chief concern about your oral health.._____

- Are you interested in whitening your teeth? _____ ☐ Yes ☐ No
- Do your teeth / gums bleed when you brush? _____ ☐ Yes ☐ No
- Do you experience dry mouth? _____ ☐ Yes ☐ No
- Do you ever have a bad taste in your mouth? _____ ☐ Yes ☐ No
- Have you been treated for Periodontal Disease? _____ ☐ Yes ☐ No
- Are you interested in clear braces or other orthodontics? _____ ☐ Yes ☐ No
- Have you been treated for TMJ? _____ ☐ Yes ☐ No

*How did you hear about us?_____

*Who may we thank for referring you? _____

Howard Family Dental

Cancellation Policy

The time set aside for the doctor is unique to you. No other patient will be scheduled during this time. Therefore, this office cannot accept cancellations. You must give your doctor 48 hour notice to avoid a $35.00 cancellation fee.

Scheduling Policy

20% of the treatment fee is due at scheduling. The fee will be applied toward the total treatment.

Signature_____ Date_____