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
- Would you be interested in Botox treatments ? _____ ☐ Yes ☐ No

*How did you hear about us?_____

*Who may we thank for referring you? _____