boulevard dental
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Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

PATIENT

PATIENT LAST NAME FIRST MIDDLE		PREFERRED NAME TO BE CALLED	TODAY'S DATE	☐ MALE ☐ FEMALE ☐
BIRTH DATE M. D YR	SOCIAL SECURITY NUMBER	CELLPHONE / HOME PHONE		MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP
MAILING ADDRESS		NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU NAME:		
CITY STATE ZIP		PHONE :		
HOME ADDRESS ☐SAME		RELATIONSHIP		
EMPLOYER		OCCUPATION		
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?				

PRIMARY DENTAL INSURANCE ☐NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	

SECONDARY DENTAL INSURANCE ☐NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	

DENTAL HISTORY:

HOW OFTEN DO YOU HAVE YOUR TEETH CLEANED/DENTAL CHECK-UPS?

_____

WHAT DO YOU DO EACH DAY TO TAKE CARE OF YOUR TEETH AND GUMS?

_____

HAVE YOU EVER HAD ANY SPECIALIZED DENTAL TREATMENT? ……..…… .YES …..NO
HAVE YOU EVER HAD AN UNUSUAL REACTION TO A DENTAL PROCEDURE OR ANESTHETIC? …… YES….. NO
HAVE YOU EVER EXPERIENCED BLEEDING/COMPLICATIONS FOLLOWING DENTAL TREATMENT? ……...YES …..NO
IF YES, EXPLAIN: _____
HAVE YOU HAD ANY INJURY TO YOUR TEETH, JAWS OR FACE? ……. YES …..NO

CURRENT DENTAL CONCERNS:

WHAT IS YOUR MAJOR DENTAL CONCERN?

_____

ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? ..... YES .....NO
DO YOUR GUMS BLEED WHEN YOU BRUSH YOUR TEETH OR WHEN YOU EAT? …… YES .....NO
DO YOU CLENCH OR GRIND YOUR TEETH? …….. YES ….NO
DOES FOOD OR DENTAL FLOSS CATCH BETWEEN YOUR TEETH? …….. YES ….NO
ARE SOME OF YOUR TEETH BECOMING LOOSE? ……...YES.... ..NO
ARE THERE SPACES BETWEEN YOUR TEETH NOW WHERE THERE WERE NONE BEFORE? ….... YES .....NO
ARE YOUR TEETH SENSITIVE TO HOT, COLD, OR PRESSURE? ……..... YES .....NO
DO ANY OF YOUR TEETH ACHE? …….. YES ….NO
DO YOU EXPERIENCE PAIN OR CLICKING IN YOUR JAW JOINTS? ……..….. YES ….NO
ARE THERE ANY SORES OR GROWTHS IN YOUR MOUTH? …….. YES... .NO
ARE YOU WORRIED ABOUT RECEIVING DENTAL TREATMENT? ……..… YES ….NO

SIGNATURE OF PATIENT: I UNDERSTAND THE NEED FOR THESE QUESTIONS TO BE ANSWERED TRUTHFULLY. TO THE BEST OMY KNOWLEDGE, THE ANSWERS I HAVE GIVEN ARE ACCURATE. I ALSO UNDERSTAND IT IS VERY IMPORTANT TO REPORT ANY CHANGES IN MY MEDICAL OR DENTAL STATUS TO THE DENTIST AT THE EARLIEST POSSIBLE TIME, AND I AGREE TO DO SO.

I GIVE MY PERMISSION TO THE DENTIST TO OBTAIN FROM ANY PHYSICIAN OR DENTIST, ANY ADDITIONAL INFORMATION REGARDING MY MEDICAL HISTORY NEEDED TO PROVIDE ME TO THE BEST DENTAL TREATMENT POSSIBLE.

PERSON COMPLETING FORM: SIGNATURE: _____

DATE:_____

IF OTHER THAN PATIENT, INDICATE RELATIONSHIP:

_____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco?

❑ yes ❑ no

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

List of medications you are currently taking

_____
_____
_____
_____
_____

Name and contact information of your

physician:_____

Do you have any disease, condition, or problem not listed

above?_____

_____

Please add anything else you would like us to know

about:_____

Signature of patient (or parent) _____ Date _____