GORDON Center for General and Advanced Dentistry

Please fill out this patient information form giving particular attention to the dental and medical health sections. Dr. Gordon will go over these sections with you. A clear understanding of your personal health profile ensures safe, appropriate treatment.

PATIENT INFORMATION

DATE__________________________

Mr. Mrs. Ms. Mx. Dr.

____ BIRTHDATE____________________________

PATIENT'S LAST NAME FIRST MIDDLE INITIAL

HOME ADDRESS ____

CITY______________________________________ STATE ______________ZIP CODE ______________________

HOME PHONE______________________________ BUSINESS PHONE ______________________________

CELL PHONE______________________________ EMAIL ______________________________

SOCIAL SECURITY NUMBER______________________________ EMPLOYER______________________________

HOW WOULD YOU PREFER TO BE CONTACTED? ____text ____ email ____home ph ____cell ____work ph

REFERRED BY____

DENTAL HISTORY

CHIEF ORAL COMPLAINT OR REASON FOR TODAY'S VISIT ______________________________

DATE OF LAST DENTAL EXAM_______________ ANY PREVIOUS MAJOR DENTAL TREATMENT ☐ YES ☐ NO WHEN ______________

WHEN WAS YOUR LAST FULL MOUTH X-RAY TAKEN? ______________ WHEN WAS YOUR LAST CLEANING? ____________________

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING: - INDICATE WITH A (✔)

- ☐ Teeth sensitive to cold, heat, sweets, or pressure
- ☐ Bleeding gums
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits, i.e., fingernail biting, cheek biting, etc.
- ☐ Cigarettes, pipe or cigar smoking, chewing tobacco
- ☐ Texture of toothbrush, Soft/Med/Hard____________
- ☐ Frequency of brushing
- ☐ Dental Floss
- ☐ Interdental stimulators
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements

MEDICAL HISTORY

PHYSICIAN______________________________ PHONE NUMBER ______________________________

ARE YOU IN GOOD HEALTH?________ IF NO, EXPLAIN ______________________________

DO YOU HAVE ANY EXISTING ILLNESS?_________ IF YES, EXPLAIN______________________________

HAVE YOU BEEN HOSPITALIZED IN THE PAST TWO YEARS?_______ IF YES, EXPLAIN ______________________________

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DO YOU BLEED EXCESSIVELY WHEN CUT? _____________DO YOU SMOKE?_______________ IF YES, HOW MUCH _______________

ARE YOU TAKING ANY MEDICATION, PILLS OR DRUGS? ___________IF SO, PLEASE LIST ______________________________

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DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH A (✔)

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Blood or AIDS related disease
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Diabetes
- ☐ Stroke
- ☐ Epilepsy or seizures
- ☐ Arthritis
- ☐ Tumor history/cancer
- ☐ Radiation treatment
- ☐ Liver disease or Hepatitis
- ☐ Kidney disease
- ☐ Sinus problems
- ☐ Asthma
- ☐ Sleep apnea
- ☐ CPAP machine
- ☐ Headaches, stress or migraines
- ☐ Osteoporosis
- ☐ Joint replacement
- ☐ Bisphosphonates
  - ☐ Aredia I.V., Reclast I.V.
  - ☐ Zometa I.V.
  - ☐ Fosamax, Actinel, Boniva
- ☐ Allergy to:
  - ☐ latex
  - ☐ pain medication
  - ☐ penicillin
  - ☐ other antibiotics
  - ☐ local anesthetics
  - ☐ other
- ☐ Are you pregnant?___________

IF YES, TO ANY OF THE QUESTIONS ABOVE. PLEASE EXPLAIN______________________________

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FINANCIAL

This dental office does not participate with any insurance companies. We will submit insurance and/or pre-authorization forms for your insurance to reimburse you directly. Payment is due at time of service.

PERSON RESPONSIBLE FOR ACCOUNT ______________________________ RELATIONSHIP TO YOU ________________________

DENTAL INSURANCE CARRIER______________________________ EMPLOYER ______________________________

POLICY HOLDER______________________________ PH DOB____________________ PH SSN ____________________

GROUP #______________________________ SUBSCRIBER ID ______________________________

I AGREE TO ASSUME FULL FINANCIAL RESPONSIBILITY FOR ALL TREATMENT RENDERED.

SIGNATURE ____ DATE_______________