Maple Park Dental is pleased to welcome you to our practice. Please take a few minutes to fill out these forms as completely as you can. If you have questions we'll be glad to help you. We look forward to assist you in maintaining your dental health.

Patient Information

Whom may we thank for referring you to our office? ☐Friend/Family, please list name: _____

☐Yellow Pages ☐Insurance: _____ ☐Internet /Ad: _____ ☐Sign/Location_____ ☐Other:_____

Patient Name_____
Last First Middle Preferred

Address_____
Street Apt # City State Zip

Home # (____)_____ **Work #** (____) _____ **Cellphone #** (____)_____

E-Mail _____ (to receive appointment reminder emails, promotions and newsletters)

Birthdate ___/___/___ **SSN** _____-_____-_____ **Sex** ☐M ☐F ☐**Single** ☐**Married** ☐**Child** ☐**Other**

Occupation / Student _____ **Employed By /School**_____

In case of emergency who should be notified? _____Relationship _____Phone#(____)_____

Responsible Party's Name_____
(IF different from above **)** Last First Middle Preferred
Address_____
Street Apt # City State Zip
Home # (_____)_____ Work # (_____)_____ Birthdate ___/___/___ SSN _____-_____-_____
Relationship to Patient _____

Medical History

Physician's Name _____ #(___)_____ Pharmacy _____ # (___)_____

Check (✓) if you have or have had any of the following:

☐Allergies	☐Cortisone Treatments	☐Low Blood Pressure	☐Sinus Problems
☐Anemia	☐Cough, Persistent	☐HIV/AIDS **(circle)**	☐Skin Rash
☐Arthritis / Rheumatism **(circle)**	☐Diabetes	☐Kidney Disease	☐Stroke
☐Artificial Heart Valves	☐Epilepsy	☐Liver Disease	☐Thyroid Problems
☐Artificial Joints (hip/knee)	☐Fainting	☐Mitral Valve Prolapse	☐Tobacco Habit
☐Asthma	☐Glaucoma	☐Neurological Conditions	☐Tonsillitis
☐Back Problems	☐Hearing loss	☐Pacemaker	☐Tuberculosis
☐Blood Disease	☐Headaches	☐Psychiatric Care	☐Ulcer
☐Blood Transfusion	☐Heart Problems	☐Radiation Treatment	☐Latex Allergy
☐Cancer	☐Hemophilia	☐Respiratory Disease	☐Hospitalization
☐Chemical Dependency	☐Hepatitis A B C or D **(circle)**	☐Rheumatic Fever	reason:_____
☐Chemotherapy	☐High Blood Pressure	☐Scarlet Fever	☐Other: _____
☐Circulatory Problems		☐Shortness of Breath _____	

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No
Have you ever taken the drug FenPhen? ☐Yes ☐No Have you ever been tested for metal allergies? ☐Yes ☐No
Have you been told by your physician to pre-medicate with antibiotics before dental treatments? ☐Yes ☐No
If Yes, please note condition requiring antibiotics: _____

Medicine Allergies: ☐None ☐Aspirin ☐Barbiturates ☐Codeine ☐Local Anesthetic ☐Penicillin ☐Sulfa ☐Other_____

Medications: list all current medications you are taking:_____
_____

Dental History and Questionnaire

Reason for your initial dental visit _____
Date of your last dental visit _____ Date of last dental x-rays _____
Former Dentist _____City/State _____ Phone # (____)_____
Would you like us to request previous dental records? ☐Yes ☐No
Please sign to authorize us to request records*_____
(*Some dental offices charge the patient for duplication of records. If this is the case, we will discuss the feasibility of the records transfer.)

Check (✓) if any of the following apply to you:

☐Bad Taste
☐Bad Breath
☐Bleeding Gums
☐Blisters on lips or mouth
☐Broken Fillings
☐Burning sensation on tongue
☐Chew on one side of mouth
☐Cigarette, pipe or cigar smoking
☐Clicking or popping jaw
☐Dark teeth
☐Dry mouth
☐Fingernail biting
☐Floss shreds when flossing
☐Food collection between teeth
☐Grinding teeth
☐Crooked teeth
☐Gums swollen or tender
☐Jaw pain or tiredness
☐Lip or cheek biting
☐Loose teeth
☐Mouth breathing
☐Mouth pain, brushing
☐Prior orthodontic treatment
☐Prior periodontal treatment
☐Sensitivity to cold
☐Sensitivity to heat
☐Sensitivity to sweets
☐Sensitivity to biting
☐Sores or growths in your mouth
☐Have whitened teeth

Has a fear of dental treatment prevented you from seeking dental care in the past? ☐Yes ☐No
Has time ever been a factor in postponing your dental work done? ☐Yes ☐No
Has the cost of dental treatment been a concern for you? ☐Yes ☐No
Are you happy with the appearance of your smile? ☐Yes ☐No If no, what would you change?_____

Other concerns: _____

NOTE: Our office uses photographs of our patients for identification purposes only. Photographs of your teeth will be taken as part of your comprehensive dental exam.

If you do not wish for the <u>full face</u> photo to be taken, please initial here _____.

Thank you.

Signature

All the information on these forms are correct and complete to the best of my knowledge. I will not hold my dentist or any member of his team responsible for any errors or omissions that I may have made in the completion of these forms.

Patient Name_____Signature_____Date____/____/_____
(Patient or Parent/Guardian)