Tyson Dental
FAMILY & COSMETIC DENTISTRY

Welcome to our office. Thank you for the confidence you place with us to provide your dental care. In order for us to best serve you, please complete the following form. This information will aid us in providing the best services to meet your dental needs. If any of this information changes at any point, please let us know. All info will be kept strictly confidential and not shared. If you have any questions, please don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____
Last First MI

Home address: _____
Street Apt City State Zip

Phone – Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner ☐

Social Security #: _____ Email: _____

Driver's License #: _____ Driver's License State: _____

Employer: _____ Occupation: _____

Has any member of your family been treated in our practice? Yes / No If yes, name of patient: _____

How did you hear about our practice? _____

WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY?

Name: _____ Phone #: _____ Relationship: _____

Address: _____

PRIMARY INSURANCE: Name of subscriber: _____ Employer: _____

Name of insurance company: _____ Social Security # of subscriber: _____

Address of insurance company: _____

Phone # of insurance company: _____ Group #: _____ Birthday of subscriber: _____

SECONDARY INSURANCE: Name of subscriber: _____ Employer: _____

Name of insurance company: _____ Social Security # of subscriber: _____

Address of insurance company: _____

Phone # of insurance company: _____ Group #: _____ Birthday of subscriber: _____

I certify that all the information above is correct to the best of my knowledge. I agree to notify this office of any changes to the above information as soon as reasonably possible.

Signature of patient (or legal guardian if minor): _____ **Date:** _____

Health Information

Patient's Name _____ Date of Birth _____

What is your main dental concern for today's visit? _____

Oral Health (Circle Yes or No)

1. Yes / No - Do you currently have any known dental problems?
2. Yes / No - Are any of your teeth sensitive to hot, cold, biting pressure, or sweets?
3. Yes / No - Do your gums bleed when brushing or flossing?
4. Yes / No - Have you ever been told you have periodontal (gum) disease?
5. Yes / No - Have you had a complete set of dental x-rays in the past year?
6. Yes / No - Do your jaw joints (TMJ) click, pop, or cause pain?
7. Yes / No - Do you clinch or grind your teeth?
8. Yes / No - Have you had your wisdom teeth removed?
9. Yes / No - Do your teeth show signs of chipping and wear?
10. Yes / No - Do you have a replacement of any type for missing teeth?
11. Yes / No - Have you ever had any unfavorable dental experiences?
12. Yes / No - Is there anything you would like to change about your smile?

Medical Health

Physician's Name _____ Date of Last Visit _____

1. Yes / No - Are you under the care of a physician now? If yes, reason(s) _____
2. Yes / No - Have you been hospitalized in the past 5 years? _____
3. Yes / No - Have you had any serious illnesses or operations? _____
4. Yes / No - Are you currently taking any medications, pills, or drugs? Please list _____

   _____
5. Yes / No - Are you allergic to any medications or other substances? (Circle all that apply)

   Aspirin Penicillin Other Antibiotics Codeine Anesthetics Metals Latex Other _____
6. Do you have, or have you ever had, any of the following?

Yes / No – Any Heart Problems
Yes / No – Artificial Joints or Valves
Yes / No – Pacemaker
Yes / No – High Blood Pressure
Yes / No – Low Blood Pressure
Yes / No – Rheumatic Fever
Yes / No – Stroke

Yes / No – Diabetes
Yes / No – Cancer/Tumor
Yes / No – Excessive Bleeding
Yes / No – AIDS/HIV
Yes / No – Hepatitis
Yes / No – Kidney Disease
Yes / No – STDs

Yes / No - Tuberculosis
Yes / No – Fainting Spells
Yes / No – Epilepsy/Seizures
Yes / No – Thyroid Problems
Yes / No –Psychiatric Treatment

7. Yes / No – Do you have any disease, conditions, or condition not listed above? Please List _____
8. Yes / No – Do you require antibiotic premedication for dental treatment?
9. **Women**: (Check if applicable) ☐ Pregnant (Due Date) ☐ Nursing ☐ Taking Birth Control
10. Is there anything else you would like for us to know about? _____

I certify that all the information above is true and correct to the best of my knowledge. I understand that an accurate medical and dental history is necessary to safely and completely treat my dental needs. I agree to let this office know as soon as possible if any of this information changes.

_____ _____

Patient's Signature (or Parent/Guardian) Date