LA CASA Family Health Center

Welcome!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet your dental health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We will be happy to help!

Patient Information (CONFIDENTIAL)

Name_____ Birth Date_____

Physician_____ Date of Last Exam_____

Person to Contact in Case of Emergency_____ Phone_____

Patient Medical History

	Y	N
1.) Are you under medical treatment now?	☐	☐
2.) Have you been hospitalized in the past 5 years?	☐	☐
3.) Do you use tobacco?	☐	☐
4.) Do you take any blood thinners including Aspirin?	☐	☐
5.) Have you had a persistent cough for more than 3 weeks?	☐	☐
6.) Women Only:		
a. Are you pregnant or think you may be pregnant?	☐	☐
b. Are you nursing?	☐	☐
c. Are you taking oral contraceptives?	☐	☐
7.) Are you taking bisphosphonate drugs for bone disease? (i.e. Zometa, Fosamax, Boniva)	☐	☐

	Y	N
8.) Are you allergic to or have you had any reactions to the following?		
a. Local Anesthetics (Novocaine)	☐	☐
b. Penicillin	☐	☐
c. Sulfa Drugs	☐	☐
d. Codeine	☐	☐
e. Any Metals (Mercury)	☐	☐
f. Latex Rubber	☐	☐
g. Other _____	☐	☐

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

AIDS/HIV Infection	☐	Fainting/Seizures	☐	Liver Disease	☐
Anemia	☐	Glaucoma	☐	Mitral Valve Prolapse	☐
Angina	☐	Hay Fever/Allergies	☐	Radiation Therapy	☐
Arthritis	☐	Heart Attack	☐	Respiratory Problems	☐
Asthma	☐	Heart Disease	☐	Rheumatic Fever	☐
Cancer	☐	Heart Murmur	☐	Sexually Transmitted Disease	☐
Cardiac Pacemaker	☐	Hepatitis	☐	Stomach Problems/Ulcers	☐
Chest Pain	☐	High Blood Pressure	☐	Stroke	☐
Diabetes	☐	Jaundice	☐	Thyroid Problems	☐
Emphysema	☐	Joint Replacement/Implant	☐	Tuberculosis	☐
Epilepsy/Convulsions	☐	Kidney Disease	☐	Other_____	☐

Patient Dental History

	Y	N
1.) Do your gums bleed while brushing or flossing?	☐	☐
2.) Are your teeth sensitive to hot or cold?	☐	☐
3.) Are your teeth sensitive to sweet or sour?	☐	☐
4.) Do you feel pain in any of your teeth?	☐	☐
5.) Do you wear partials or dentures?	☐	☐
6.) Have you had any head, neck, or jaw injuries?	☐	☐
7.) Do you have frequent headaches?	☐	☐
8.) Do you clench or grind your teeth?	☐	☐
9.) Do you bite your lips or cheeks frequently?	☐	☐

	Y	N
10.) Have you had any orthodontic treatment?	☐	☐
11.) Have you received instruction regarding the care of your teeth and gums?	☐	☐
12.) Have you had your teeth cleaned in the last year?	☐	☐
13.) Have you had any difficult extractions?	☐	☐
14.) Have you had prolonged bleeding following extractions?	☐	☐
15.) Do you like your smile?	☐	☐

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health and the health of others.

X_____ _____

Signature of Patient (or parent/guardian if minor) Date

Dr. Notes

Office Use ONLY