Jennifer Siwula Gill, DMD, LLC
322 Pittsburgh Street
Scottdale, PA 15683

(724)887-4111

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Occupation:

_____

Emergency contact person:

_____

Whom may we thank for referring you to our office?

_____

Relatives that are patients in our practice:

_____

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Primary Care Physician and Phone Number:

Are you under the care of a physician for any medical conditions?

Have you been hospitalized in the past 2 years?

Have you ever had major surgery?

FEMALES: Are you pregnant or nursing? Are you taking hormones or oral contraceptives?

Are you or have you taken Fosamax, Boniva, Actonel or any other medications for osteoporosis?

Are you taking any prescription or non-prescription medications, vitamins or herbal supplements?

Are you allergic to any medications or to latex ? (please specify)

Have you ever had a negative reaction to local anesthesia?

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Do you need to premedicate prior to dental treatment?

◯ Yes ◯ No

If yes, what do you premedicate for? What antibiotic do you premedicate with?

Have you ever had any of the following?

☐ Artificial Heart Valve	☐ Liver Disease	☐ Joint Replacement
☐ Congenital Heart Disease	☐ Hepatitis	☐ Arthritis
☐ Heart Problems	☐ Cancer	☐ Thyroid Disease
☐ Abnormal Blood Pressure	☐ Chemo	☐ Kidney Disease
☐ Angina	☐ Radiation	☐ Diabetes
☐ Heart Murmur/MVP	☐ Leukemia	☐ Glaucoma
☐ Rheumatic Fever	☐ Anemia	☐ Organ Transplant
☐ Pacemaker	☐ Respiratory Problems	☐ Epilepsy
☐ Stroke	☐ Tuberculosis	☐ Fainting/Vertigo
☐ Congestive Heart Failure	☐ Allergies	☐ Alzheimers
☐ AIDS	☐ Sinus Problems	☐ Parkinsons Disease
☐ HIV	☐ Asthma	☐ Mental Illness/Depression
☐ STDs	☐ Digestive Disorders	☐ Nervous Disorders/Anxiety
☐ Cold Sores	☐ Acid Reflux	☐ Drug Addiction

Do you have any other diseases, conditions, or problems not listed here?

Signature: _____ Date:

Response Date:

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Are you having any dental problems that require immediate attention?

◯ Yes ◯ No

If yes, please explain:

Do you have any sensitivity to hot, cold, sweets or chewing?

◯ Yes ◯ No

If yes, please explain:

Do you usually have many cavities?

◯ Yes ◯ No

If yes, please explain:

When and where was your last dental visit?

What was done at your last dental visitt?

How often did you see your dentist?

Do you have recent x-rays?

◯ Yes ◯ No

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Have you had periodontal treatment? If yes, when did you have treatment and what was done?

How often do you brush your teeth?

How often do you floss?

Do your gums bleed when you brush or floss?

◯ Yes ◯ No

Do you smoke or use tobacco?

◯ Yes ◯ No

If yes, when did you begin using tobacco and how much do you currently use?

Do you clench or grind your teeth?

◯ Yes ◯ No

Do your jaws ever feel tired?

◯ Yes ◯ No

Do you get frequent headaches?

◯ Yes ◯ No

Can you chew on both sides of your mouth?

◯ Yes ◯ No

Do you have any noticeable wear on your teeth?

◯ Yes ◯ No

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Have you ever had orthodontic treatment? If yes, when and with who?

Do you have any missing teeth?

◯ Yes ◯ No

Have they been replaced. If yes, how?

How do you feel about the appearance of your smile?

Have you ever had cosmetic dentistry done to improve your appearance?

◯ Yes ◯ No

If yes, what was done?

If no, have you ever considered or are you interested in cosmetic dentistry to improve your appearance?

◯ Yes ◯ No

Have you ever had an unpleasant dental experience? If yes, explain.

Please add anything you feel is important for us to be aware of:

Response Date: