Patient Information

Today's Date : _____ Date of Birth : _____

Patient Name : _____

Social Security : _____ Gender : _____ Marital Status: _____

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

Address : _____
Street City State Zip Code

Employer : _____ Email : _____

Emergency Contact : _____
Name Phone Number Relationship

Dental History

Why have you come to the dentist today? : _____

_____

Previous Dentist : _____ Date of last visit : _____
Your current dental health is : Good Fair Poor
Type of bristles on your toothbrush? : Hard Medium Soft
Have you had an unfavorable dental experience? : _____
Are your teeth sensitive to heat, cold, pressure, or anything else? : _____

Are you currently in pain? : ❑Y ❑N
Do you floss daily? : ❑Y ❑N
Do you have loose teeth? : ❑Y ❑N
Do you clench or grind your teeth? : ❑Y ❑N
Do you have swollen glands? : ❑Y ❑N
Do you have areas of food traps? : ❑Y ❑N

Do you require antibiotics before dental treatment : ❑Y ❑N
Do you have broken or missing teeth? : ❑Y ❑N
Do you have your wisdom teeth? : ❑Y ❑N
Do you have swelling or lumps in your mouth? : ❑Y ❑N
Do you have dry mouth? : ❑Y ❑N
Do you have clicking or jaw popping? : ❑Y ❑N

Do you or have you had periodontal/gum disease? : ❑Y ❑N
How do you feel about dental treatment? : ❑ Relaxed ❑ A little uneasy ❑ Anxious

Medical History

Do you have a personal Physician? : ❑ Y ❑ N Date of last visit: _____
Physician's Name: _____ Phone : _____

Dr. Carly Christoferson Petersen, DMD
(503) 636-8446 (Office) 3900 Douglas Way Lake Oswego, OR 97035
www.TheDentistOnBoonesFerry.com

Are you currently under the care of a Physician? If yes please explain :

_____

Do you have or have you experienced the following?

Y	N	Abnormal Bleeding	Y	N	Epilepsy	Y	N	Mitral Valve Prolapse
Y	N	Alcohol Abuse	Y	N	Erectile Dysfunction	Y	N	Pacemaker
Y	N	Anemia	Y	N	Fainting Spells	Y	N	Persistent Cough
Y	N	Arthritis	Y	N	Fever Blisters	Y	N	Psychiatric Problems
Y	N	Artificial Bones/Joints	Y	N	Glaucoma	Y	N	Radiation Treatment
Y	N	Artificial Valves	Y	N	Hay Fever	Y	N	Seizures
Y	N	Asthma	Y	N	Heart Attack	Y	N	Shingles
Y	N	Blood Transfusion	Y	N	Heart Murmur	Y	N	Sickle Cell Disease
Y	N	Cancer	Y	N	Heart Surgery	Y	N	Sinus Problems
Y	N	Chemotherapy	Y	N	Hemophilia	Y	N	Steroid Therapy
Y	N	Chicken Pox	Y	N	Hepatitis	Y	N	Stroke
Y	N	Chronic Headaches	Y	N	Herpes	Y	N	Thyroid Problems
Y	N	Colitis	Y	N	High / Low Blood Pressure	Y	N	Tonsillitis
Y	N	Congenital Heart Disease	Y	N	HIV+ / AIDS	Y	N	Ulcers
Y	N	Diabetes	Y	N	Kidney Problems	Y	N	Venereal disease
Y	N	Difficulty Breathing	Y	N	Liver Disease			
Y	N	Drug Abuse	Y	N	Lupus			

Do you smoke or use tobacco in any other form? : ❑ Y ❑ N

Have you ever taking Bisphosphonates (Fosamax, etc.) ? : ❑ Y ❑ N

For Women : Are you taking birth control pills? : ❑ Y ❑ N

Are you Pregnant? : ❑ Y ❑ N ❑ Unsure

If yes Week # : _____ Are you nursing? : ❑ Y ❑ N

Please list any serious medical condition(s) that you have experienced : _____

Are you taking any prescription or over the counter drugs ? : ❑Y ❑N If yes, please list each one and why :

_____ _____

_____ _____

Are you allergic to any of the following?

Aspirin	Codeine	Erythromycin	Latex	Sedatives	Tetracycline
Barbiturates	Dental Anesthetics	Metals	Penicillin	Sulfa Drugs	Other

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I understand that any schedule changes with less than 48 hours notice may result in charges for time reserved.

X _____ X _____

Dentist Date Signature Date

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