

The Bonner Dental Network, PC Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
 Gender: _____ Marital Status: _____
 Social Security #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ (Cell) _____
 EMAIL Address _____ Emergency Contact _____ PH# _____
 Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? Please circle yes or no:

AIDS/HIV	Y/N	Excessive Bleeding	Y/N	Mental Disorders	Y/N	Tuberculosis	Y/N
Drug Allergies:		Fainting	Y/N	Mitral Valve Prolapse		Tumors	Y/N
_____		Glaucoma	Y/N	Nervous Disorders	Y/N	Ulcers	Y/N
_____		Growths	Y/N	Pacemaker	Y/N	Venereal Disease	Y/N
Anemia	Y/N	Hay Fever	Y/N	Pregnant	Y/N	OTHER:	
Arthritis	Y/N	Head Injuries	Y/N	Due date: _____		<input type="checkbox"/> List Prescribed	
Artificial Joints	Y/N	Heart Disease	Y/N	Radiation Treatment	Y/N	medications	
Asthma	Y/N	Heart Murmur	Y/N	Respiratory Problems		taken _____	
Blood		Hepatitis	Y/N		Y/N	_____	
Disease/Hemophilia		High Blood Pressure	Y/N	Rheumatic Fever	Y/N	_____	
_____	Y/N	Jaundice	Y/N	Rheumatism	Y/N	<input type="checkbox"/>	
Cancer	Y/N	Kidney Disease	Y/N	Sinus Problems	Y/N	BP _____ / _____	
Diabetes	Y/N	Latex Allergy	Y/N	Stomach Problems	Y/N		
Dizziness	Y/N	Liver Disease	Y/N	Stroke	Y/N		
Epilepsy	Y/N					PULSE _____	

Dental History

1. Do your gums bleed while brushing or flossing? __yes __no
2. Are your teeth sensitive to hot or cold liquids/foods? __yes __no
3. Are your teeth sensitive to sweet or sour liquids/foods? __yes __no
4. Do you feel pain to any of your teeth? __yes __no
5. Do you have any sores or lumps in or near your mouth? __yes __no
6. Have you had any head, neck or jaw injuries? __yes __no
 - Clicking? __yes __no
 - Difficulty in opening or closing? __yes __no
7. Do you clench or grind your teeth? __yes __no
8. Have you ever had prolonged bleeding following extractions? __yes __no
9. Do you bite your lips or cheeks frequently? __yes __no

RESP: _____

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Please provide following information for emergency purposes only
- Physician or Medical facility: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____ Reviewed by: _____ Date: _____