Stephen Family Dentistry

2037 S Buckner Blvd, Dallas, TX 75217

NEW PATIENT FORM

Medical and dental history

PATIENT INFORMATION

PATIENT NAME		**TODAY'S DATE**	
HOME ADDRESS		**DATE OF BIRTH**	
		HOME PHONE	
E-MAIL ADDRESS		**CELL PHONE**	
BUSINESS ADDRESS		**BUSINESS PHONE**	
		SS # / SIN	

PHYSICIAN | **OFFICE PHONE** | **DATE OF LAST EXAM**

MEDICAL HISTORY QUESTIONS

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s), including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking?		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use alcohol, cocaine or other drugs?	☐	☐
7. Are you wearing contact lenses?	☐	☐

8. Are you allergic to or have you had any reactions to any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Local anesthetics (e.g., novocaine)	☐	☐	Barbiturates	☐	☐	Aspirin
☐	☐	Penicillin or other antibiotics	☐	☐	Sedatives	☐	☐	Other
☐	☐	Sulfa drugs	☐	☐	Iodine			

OTHER REACTION/DETAILS

	YES	NO
9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
10. WOMEN ONLY:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

MEDICAL CONDITIONS

11. Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	High blood pressure	☐	☐	Heart disease	☐	☐	Chest pains
☐	☐	Heart attack	☐	☐	Cardiac pacemaker	☐	☐	Easily winded
☐	☐	Rheumatic fever	☐	☐	Heart murmur	☐	☐	Stroke
☐	☐	Swollen ankles	☐	☐	Angina	☐	☐	Hay fever / allergies
☐	☐	Fainting / seizures	☐	☐	Frequently tired	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Anemia	☐	☐	Radiation therapy
☐	☐	Low blood pressure	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Epilepsy / convulsions	☐	☐	Cancer	☐	☐	Recent weight loss
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Liver disease
☐	☐	Diabetes	☐	☐	Joint replacement or implant	☐	☐	Heart trouble
☐	☐	Kidney disease	☐	☐	Hepatitis / jaundice	☐	☐	Respiratory problems
☐	☐	AIDS or HIV infection	☐	☐	Sexually transmitted disease	☐	☐	Other
☐	☐	Thyroid problem	☐	☐	Stomach troubles / ulcers			

OTHER DETAILS

COMMENTS

DENTIST SIGNATURE | **DATE**

PATIENT NAME

PATIENT DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
b) Pain (joint, ear, or side of face)?	☐	☐
c) Difficulty opening or closing?	☐	☐
d) Difficulty chewing?	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic work?	☐	☐
13. Have you ever had prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

CERTIFICATION AND SIGNATURE

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

PRINTED NAME | **PATIENT, PARENT OR GUARDIAN SIGNATURE** | **DATE**

Signature may be typed in the fillable PDF or signed after printing.