RED HILLS
DENTAL ASSOCIATES

1957 Raymond Diehl Rd. • Tallahassee, FL 32308 • (850) 385-2003

Patient Information

Patient Name:_____ Nickname:_____

Home Address:_____

City:_____ State:_____ Zip: _____

Home:_____ Work: _____ Cell:_____

DL#:_____ SS#:_____ Birthdate:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

Email:_____ (Used for appointment reminder and in-office use only)

Employed by:_____ Occupation: _____

Spouse Name:_____ Occupation: _____

Spouse Employed by:_____ Work Phone: _____

Name of person responsible for account:_____ Relationship:_____

Address of responsible party: _____

Home:_____ Work: _____ Cell:_____

Insurance

(Please provide a copy of your insurance card. Without the proper information we are not able to assist you in filing your Dental Insurance.)

Insurance Co. _____ Employer: _____

Insured Name:_____ DOB:_____ SS#:_____

Insured Address (if different from above): _____

City:_____ State:_____ Zip_____

Dental History

Reason for today's visit? _____

Name of previous dentist:_____ Last dental visit? _____

Phone Number:_____ City: _____

	YES	NO
Do you feel apprehensive about having dental treatment?	☐	☐
Have you ever had a bad experience in a dental office?	☐	☐
Do your gums bleed or feel tender or irritated?	☐	☐
Are you sensitive to: (check one) ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure		
Are you aware of grinding or clenching your teeth?	☐	☐
Do you have: (check one) ☐ Loose ☐ Tipped ☐ Shifting Teeth?		
Have you worn braces on your teeth? (Orthodontics)	☐	☐
Do you have discolored teeth that bother you?	☐	☐
Are you unhappy with the appearance of your teeth?	☐	☐
Would you like your smile to look better or different?	☐	☐

How do you feel about your teeth?_____

Medical History

Family Physician_____Phone_____

	YES	NO
Are you presently in good health?	☐	☐
Are you under a physician's care now?	☐	☐
For what reason? _____		
Are you currently taking any drugs or medications?	☐	☐
Please list: _____		
Have you ever had excessive bleeding requiring special treatment?	☐	☐
Are you pregnant?	☐	☐
Do you use any type of tobacco product?	☐	☐
Do you use any type of blood thinner medication including aspirin?	☐	☐
Do you take any drugs for Osteoporosis to prevent bone loss or IV bisphosphonates?	☐	☐

Please check any of the following you are allergic to or have had adverse reactions to:

- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Iodine
- ☐ Latex
- ☐ Erythromycin
- ☐ Percodan
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Valium
- ☐ Other: _____

Please check any of the following which you have had or have at the present:

- ☐ AIDS or HIV Positive
- ☐ Alcoholism
- ☐ Allergies or Hives
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arteriosclerosis
- ☐ Arthritis/Rheumatoid
- ☐ Artificial Heart Valve
- ☐ Artificial Joint/Implants
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Clenching/Grinding Teeth
- ☐ Cold Sores
- ☐ Congenital Heart Lesions
- ☐ Cortisone Medication
- ☐ Diabetes
- ☐ Difficulty Sleeping
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injury
- ☐ Headaches
- ☐ Heart Disease/Attack
- ☐ Heart Murmur
- ☐ Heart Failure
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Kidney Trouble
- ☐ Liver Disease
- ☐ Metal Allergies
- ☐ Mitral Valve Prolapse
- ☐ Muscle Spasms
- ☐ Nervousness Problems
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Persistent Cough
- ☐ Popping Jaw Joints
- ☐ Previous Gum Disease
- ☐ Previous Orthodontic
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sleep Apnea
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Swallowing Problems
- ☐ Thyroid Disease
- ☐ TMJ Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Any other medical problem you are having that is not listed? _____

To the best of my knowledge, all of the above answers are true and correct. If I ever have a change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail:

Patient/Guardian Signature:_____ **Date:**_____