Welcome!

BARNWELL FAMILY DENTISTRY

Thank you for choosing Barnwell Family Dentistry. We promise to provide you with optimal dental care in a friendly and compassionate setting. Please fill out this form so that we may give you the personalized attention you deserve. If you have any questions, please ask our staff.

PATIENT INFORMATION

Name _____ (First / Middle / Last) SSN _____ Date of Birth _____ Male ☐ Female ☐

Mailing Address _____ City _____ State _____ Zip _____

Home Phone No. _____ Cell Phone No. _____ Email _____

How did you hear about us? Radio ☐ TV ☐ Friend ☐ Referral ☐ Phone Book ☐ Internet ☐ Sign ☐

EMERGENCY CONTACT: Name _____ Relationship _____ Phone No. _____

RESPONSIBLE PARTY: Name _____ SSN _____ Phone No _____

Address _____ City _____ State _____ Zip _____

EMPLOYMENT INFORMATION

Employer Name _____ Occupation _____

Employment Status: Full Time ☐ Part Time ☐ Employment Contact Name _____

Employer Address _____ City _____ State _____ Zip _____

Employer Phone No. _____

DENTAL INSURANCE INFORMATION (Please present your insurance Card and ID with this Form)

Primary Insurance

Insurance Co. _____

Policy Number. _____

Group Number _____

Are you the policyholder? Yes ☐ No ☐

IF YOU ARE NOT THE POLICY HOLDER, COMPLETE BELOW

Policyholder's Name _____

Policyholder's DOB _____

Policyholder's SSN _____

Policyholder's Address _____

Policyholder's Employer _____

Relationship to Patient Spouse ☐ Child ☐ Other ☐

Secondary Insurance Information

Insurance Co. _____

Policy Number _____

Group Number _____

Are you the policyholder? Yes ☐ No ☐

IF YOU ARE NOT THE POLICY HOLDER, COMPLETE BELOW

Policyholder's Name _____

Policyholder's DOB _____

Policyholder's SSN _____

Policyholder's Address _____

Policyholder's Employer _____

Relationship to Patient Spouse ☐ Child ☐ Other ☐

DENTAL HISTORY

	Yes	No
1. Do your gums bleed when you brush or floss?	☐	☐
2. Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
3. Do you suffer from dry mouth?	☐	☐
4. Have you had any periodontal (gum) treatments?	☐	☐
5. Have you ever had orthodontic (braces) treatments?	☐	☐
6. Have you had any problems associated with previous dental treatments?	☐	☐
7. Is your home water supply fluoridated?	☐	☐
8. Are you currently experiencing dental pain or discomfort?	☐	☐
9 Do you have earaches or neck pains?	☐	☐
10. Are you happy with your smile?	☐	☐

	Yes	No
11. Do you have any clicking, popping or discomfort in the jaw?	☐	☐
12. Do you brux or grind your teeth?	☐	☐
13. Do you have sores or ulcers in your mouth?	☐	☐
14. Do you wear dentures or partials?	☐	☐
15. Do you participate in active recreational activities?	☐	☐
16. Have you ever had a serious injury to your head or mouth?	☐	☐

17. Date of your last dental exam DD MM YYYY

18. What was done at that time? _____

19. Date of last dental x-rays DD MM YYYY

20. Anxiety seeing the dentist: ☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE

21. What is the reason for your dental visit _____

MEDICAL HISTORY

	Yes	No
1. Are you now under the care of a physician?	☐	☐
2. Physician Name:		
3. Phone		
4. Address		
5. City/State/Zip		
6. Are you in good health?	☐	☐
7. Has there been any change in your general health within the past year?	☐	☐
8. If yes, specify		
9. Date of last physical exam		
10. Do you wear contact lenses?	☐	☐
11. Are you taking or have you taken any diet drugs such as Pondimin (Fenfluramine), Redux (Dexphenfluramine) or Fen-Phen (Fenfluramine-phentermine combination)?	☐	☐
12. Are you taking or scheduled to begin taking either of the medications Alendronate (Fosamax®) or Risendronate (Actonel®)for Osteoporosis or Paget's disease?	☐	☐
13. Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, Multiple Myeloma or metastic cancer?	☐	☐
14. Treatment Date DD MM YYYY		

	Yes	No
15. Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐
16. If yes, what was the illness or problem?		
17. Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐
18. If yes, please list all, including vitamins, natural or herbal preparations and/or diet supplements.		
19. Do you use controlled substances (drugs)?	☐	☐
20. Do you use tobacco (smoking, snuff, chew)?	☐	☐
21. If yes, how interested are you in stopping? ☐ VERY ☐ SOMEWHAT ☐ NOT INTERESTED		
22. Do you drink alcoholic beverages?	☐	☐
23. If yes, how much alcohol did you drink in the last 24hours?		
24. If yes, how much do you typically drink in a week?		

WOMEN ONLY

	Yes	No
25. a. Are you pregnant?	☐	☐
b. If yes, number of weeks?		
c. Are you nursing?	☐	☐
d. Are you taking oral contraceptives?	☐	☐

JOINT REPLACEMENT(S)

	Yes	No
26. Have you had an orthopedic total Joint Replacement?	☐	☐
27. If yes, has you had any complications?	☐	☐
28. Date of surgery		
29. Has a physician recommended that you take antibiotics prior to dental treatment	☐	☐

30. Are you allergic to, or have you had a reaction to:

	Yes	No
Local anesthetics	☐	☐
Aspirin	☐	☐
Penicillin or other antibiotics	☐	☐
Barbituates, sedatives, or sleeping pills	☐	☐
Sulfa Drugs	☐	☐
Codeine or other narcotics	☐	☐

	Yes	No
Metals	☐	☐
Latex (rubber)	☐	☐
Iodine	☐	☐
Hay fever/seasonal	☐	☐
Food	☐	☐
Other	☐	☐
If yes, specify		

31. Do you have, or have you had, any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Hemophila	☐	☐	Radiation Treatments	☐	☐
Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Recent Weight Loss	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐	Renal Dialysis	☐	☐
Anemia	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Angina	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐
Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐	High Cholesterol	☐	☐	Scarlet Fever	☐	☐
Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hives or Rash	☐	☐	Shingles	☐	☐
Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐	Sickle Cell Disease	☐	☐
Asthma	☐	☐	Fainting Spells/ Dizziness	☐	☐	Irregular Heartbeat	☐	☐	Sinus Trouble	☐	☐
Blood Disease	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Spina Bifida	☐	☐
Blood Transfusion	☐	☐	Frequent Diarrhea	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐

31. CONTINUATION

	Yes	No		Yes	No		Yes	No		Yes	No
Breathing Problem	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Bruise Easily	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐	Swelling of Limbs	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Thyroid Disease	☐	☐
Chemotherapy	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis	☐	☐
Chest Pains	☐	☐	Heart Attack/ Failure	☐	☐	Osteoporosis	☐	☐	Tuberculosis	☐	☐
Cold Sores/Fever Blisters	☐	☐	Heart Murmur	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Congenital Heart Disorder	☐	☐	Heart Pacemaker	☐	☐	Parathyroid Disease	☐	☐	Ulcers	☐	☐
Convulsions	☐	☐	Heart Trouble / Disease	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐
									Yellow Jaundice	☐	☐

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes, please specify below.

AUTHORIZATION

I certify that I have read and understand the above information. The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. If I ever have any change in my health, I will inform the doctor at the next appointment. I will not hold my dentist, or any member of his staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of patient, parent or guardian	Date	Relationship to patient