Brookfield Family Dentistry, LLC

Marianne Morelli, D.M.D.

Patient Information Update

Patient Name: _____ Date: _____
Last First Middle Nickname

Gender: *Female* *Mal e* _____ Family Status: *Single* *Married* *Divorced* *Widowed* *Child*

Date of Birth: _____ Social Security Number: _____

Phone Home: _(_____)_____ Cell : _(_____)_____ Work_(_____)_____

Preferred Contact Number: ☐ Home ☐ Cell ☐ Work

Email: _____

Address: _____
Number Street Unit/Apartment Number

_____
Town State Zip Code

Health History Update

Do you need to premedicate with antibiotics for dental appointments? ☐No ☐Yes ☐Unsure

Current Height: _____ Current Weight: _____

Please check if you have had problems with any of the following:

☐ Bad Breath ☐ Grinding teeth ☐ Sensitivity to hot ☐ Food collection between teeth
☐ Bleeding gums ☐ Loose teeth or broken fillings ☐ Sensitivity to sweets ☐ Sores or growths in your mouth
☐ Clicking or popping jaw ☐ Periodontal treatment ☐ Sensitivity when biting ☐ Sensitivity to cold

How often do you floss? _____ How often do you brush? _____

Do you have a history of opioid abuse/addiction/dependence? ☐No ☐Yes

Have you been admitted to a hospital, needed emergency care or had any surgeries during the past 5 years?

☐No ☐Yes If yes, please explain _____

Have you taken medications (Fosamax, Actonel, Boniva, Reclast) to increase bone density and/or to prevent bone loss?

☐No ☐Yes If yes, How long? What type? Are you still taking?_____

(**Women**) Are you Pregnant? ☐ No ☐Yes Nursing? ☐No ☐Yes Taking Birth Control Pills? ☐No ☐Yes

Please check if you have or have had any of the following:

☐Anemia ☐Diabetes ☐HIV / AIDS ☐Sinus Problems
☐Arthritis, Rheumatism ☐Dizziness ☐Kidney Disease ☐Sleep Apnea/CPAP
☐Artificial Heart Valves* ☐Epilepsy ☐Liver Disease ☐Stroke
☐Artificial Joints* ☐Excessive Bleeding ☐Low / High Blood Pressure ☐Thyroid Problems
☐Asthma ☐Fainting ☐Mental Disorders ☐T.M.J.
☐Back Problems ☐Glaucoma ☐Mitral Valve Prolapse* ☐Tobacco Habit
☐Blood Disease ☐Hay Fever ☐Nervous Disorders ☐Tuberculosis
☐Cancer ☐Head Injuries ☐Osteoporosis* ☐Tumors
☐Chemical Dependency ☐Heart Disease ☐Pacemaker ☐_____
☐Chemo/Radiation ☐Heart Murmur* ☐Respiratory Problems ☐_____
☐Circulatory Problems ☐Hepatitis ☐Rheumatic Fever ☐_____

Medications

List medications you are currently taking:_____
_____
_____
_____

Pharmacy Name/Location:_____

Allergies

☐ Aspirin ☐ Sulfa
☐Barbiturates (Sleeping pills) ☐ Latex
☐Codeine ☐_____
☐Local Anesthetic ☐ _____
☐Penicillin ☐ _____

Signature

To the best of my knowledge, all of the preceding answers and information provided is accurate and complete. If I ever have any change in my health, I will inform the doctor and/or hygienist at the next appointment without fail.

Date _____ Signature_____