Brookfield Family Dentistry, LLC

Marianne Morelli, D.M.D.

PATIENT INFORMATION

Patient Name: _____ Date: _____

Last First Middle Nickname

Gender: *Female* *Male* _____ 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

EMERGENCY CONTACT INFORMATION

Emergency Contact: (Name and Phone Number) _____

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 alcohol/substance 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

(**Men**) Have you taken or are you currently prescribed (Viagra, Levitra, Staxyn, Cialis, Sendra or similar) Phosphodiesterase (PDE) Inhibitors? ☐ No ☐ Yes

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

☐Anemia ☐Diabetes ☐ High Blood Pressure ☐Rheumatic Fever

☐ Arthritis, Rheumatism ☐Dizziness ☐ HIV/AIDS ☐ Sinus Problems

☐ Artificial Heart Valves* ☐Epilepsy ☐ Kidney Disease ☐Sleep Apnea/CPAP

☐ Artificial Joints* ☐Excessive Bleeding ☐ Liver Disease ☐Stroke

☐ Asthma ☐Fainting ☐ Low Blood Pressure ☐Thyroid Problems

☐Back Problems ☐Glaucoma ☐ Mental Disorders ☐T.M.J.

☐Blood Disease ☐Hay Fever ☐ Mitral Valve Prolapse* ☐Tobacco Habit

☐Cancer ☐Head Injuries ☐ Nervous Disorders ☐Tuberculosis

☐Chemical Dependency ☐Heart Disease ☐ Osteoporosis* ☐Tumors

☐Chemo/Radiation ☐Heart Murmur* ☐ Pacemaker ☐ _____

☐ Circulatory Problems ☐Hepatitis ☐ Respiratory Problems ☐ _____

MEDICATIONS & PHARMACY

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_____