Rose Hill Dentistry
Family & Cosmetic Dentistry

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THANK YOU FOR TRUSTING US WITH YOUR DENTAL CARE. WE PROMISE TO DO OUR BEST TO PROVIDE YOU WITH THE FINEST CARE AVAILABLE. IF YOU HAVE ANY QUESTIONS PLEASE DO NOT HESITATE TO CALL US.

PATIENT INFORMATION

Date: _____ ☐ NEW PATIENT ☐ UPDATE

Patient: _____
LAST FIRST MI PREFERRED TITLE

☐ MALE ☐ FEMALE ☐ CHILD* ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

IF PATIENT IS A CHILD PLEASE INCLUDE GUARDIAN'S NAME:

_____

Patient Date of Birth: _____ Patient SSN: _____

Address: _____
ADDRESS LINE 1

_____ HOME: _____
CITY STATE ZIP CODE CELL: _____

E-Mail: _____

Referred by: _____

INSURANCE INFORMATION

_____ _____
Policy Holder's Name Date of Birth

_____ _____
Insurance Company/Employer Insured Member ID/SSN

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP TELEPHONE

DENTAL HISTORY

Date of Last Dental Visit: _____ Treatment Type: _____
Previous Dentist/Office: _____ Phone Number: _____

Reason for visiting today: _____

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

Check yes if you have had problems with any of the following:

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

MEDICAL HISTORY

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND THE MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY YOU WILL RECEIVE. THANK YOU FOR ANSWERING ALL THE FOLLOWING QUESTIONS.

Under a physician's care now? If yes, please explain	☐Y ☐N	.....
Have you ever been hospitalized or had major operation? If yes, please explain:	☐Y ☐N	.....
Have you ever had a serious head or neck injury? If yes, please explain:	☐Y ☐N	.....
Are you taking any medications, pills or drugs? If yes, please explain:	☐Y ☐N	.....
Do you take, or have you taken, Phen-Fen or Redux?	☐Y ☐N	
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	☐Y ☐N	
Are you on a special diet?	☐Y ☐N	
Do you use tobacco?	☐Y ☐N	
Do you use controlled substances?	☐Y ☐N	

WOMEN: ARE YOU:

TRYING TO GET PREGNANT? ☐Y ☐N TAKING ORAL CONTRACEPTIVES? ☐Y ☐N NURSING? ☐Y ☐N

ARE YOU ALLERGIC TO THE FOLLOWING?

ASPIRIN ☐ PENICILLIN ☐ CODEINE ☐ LOCAL ANESTHETICS ☐ ACRYLIC ☐ METAL ☐ LATEX ☐ SULFA DRUGS ☐

OTHER, IF YES PLEASE EXPLAIN:

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

AIDS/HIV POSITIVE ☐Y ☐N	CORTISONE MEDICINE ☐Y ☐N	HEMOPHILIA ☐Y ☐N	RADIATION TREATMENTS ☐Y ☐N
ALZHEIMER'S DISEASE ☐Y ☐N	DIABETES ☐Y ☐N	HEPATITIS A ☐Y ☐N	RECENT WEIGHT LOSS ☐Y ☐N
ANAPHYLAXIS ☐Y ☐N	DRUG ADDICTION ☐Y ☐N	HEPATITIS B OR C ☐Y ☐N	RENAL DIALYSIS ☐Y ☐N
ANEMIA ☐Y ☐N	EASILY WINDED ☐Y ☐N	HERPES ☐Y ☐N	RHEUMATIC FEVER ☐Y ☐N
ANGINA ☐Y ☐N	EMPHYSEMA ☐Y ☐N	HIGH BLOOD PRESSURE ☐Y ☐N	RHEUMATISM ☐Y ☐N
ARTHRITIS/GOUT ☐Y ☐N	EPILEPSY OR SEIZURES ☐Y ☐N	HIGH CHOLESTEROL ☐Y ☐N	SCARLET FEVER ☐Y ☐N
ARTIFICIAL HEART VALVE ☐Y ☐N	EXCESSIVE BLEEDING ☐Y ☐N	HIVES OR RASH ☐Y ☐N	SHINGLES ☐Y ☐N
ARTIFICIAL JOINT ☐Y ☐N	EXCESSIVE THIRST ☐Y ☐N	HYPOGLYCEMIA ☐Y ☐N	SICKLE CELL DISEASE ☐Y ☐N
ASTHMA ☐Y ☐N	FAINTING SPELLS/DIZZINESS ☐Y ☐N	IRREGULAR HEARTBEAT ☐Y ☐N	SINUS TROUBLE ☐Y ☐N
BLOOD DISEASE ☐Y ☐N	FREQUENT COUGH ☐Y ☐N	KIDNEY PROBLEMS ☐Y ☐N	SPINA BIFIDA ☐Y ☐N
BLOOD TRANSFUSION ☐Y ☐N	FREQUENT DIARRHEA ☐Y ☐N	LEUKEMIA ☐Y ☐N	STOMACH/INTESTINAL DISEASE ☐Y ☐N
BREATHING PROBLEM ☐Y ☐N	FREQUENT HEADACHES ☐Y ☐N	LIVER DISEASE ☐Y ☐N	STROKE ☐Y ☐N
BRUISE EASILY ☐Y ☐N	GENITAL HERPES ☐Y ☐N	LOW BLOOD PRESSURE ☐Y ☐N	SWELLING OF LIMBS ☐Y ☐N
CANCER ☐Y ☐N	GLAUCOMA ☐Y ☐N	LUNG DISEASE ☐Y ☐N	THYROID DISEASE ☐Y ☐N
CHEMOTHERAPY ☐Y ☐N	HAY FEVER ☐Y ☐N	MITRAL VALVE PROLAPSE ☐Y ☐N	TONSILLITIS ☐Y ☐N
CHEST PAINS ☐Y ☐N	HEART ATTACK/FAILURE ☐Y ☐N	OSTEOPOROSIS ☐Y ☐N	TUBERCULOSIS ☐Y ☐N
COLD SORES/FEVER BLISTERS ☐Y ☐N	HEART MURMUR ☐Y ☐N	PAIN IN JAW JOINTS ☐Y ☐N	TUMORS OF GROWTHS ☐Y ☐N
CONGENITAL HEART DISORDER ☐Y ☐N	HEART PACEMAKER ☐Y ☐N	PARATHYROID DISEASE ☐Y ☐N	ULCERS ☐Y ☐N
CONVULSIONS ☐Y ☐N	HEART TROUBLE/DISEASE ☐Y ☐N	PSYCHIATRIC CARE ☐Y ☐N	VENEREAL DISEASE ☐Y ☐N
			YELLOW JAUNDICE ☐Y ☐N

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTEN ABOVE? ☐Y ☐N .....

COMMENTS:

To my best knowledge, the questions on this form have been accurately answered. I understand by providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN **DATE**