columbus family dental care
David A. Dixon, DDS and Associates

Name ______________________________ Date of Birth ______________________

Address ______________________________ Home Phone ______________________

City ________________ State ____ Zip ______ Business Phone ______________________

E-mail address: ______________________________ SSN: ______________________

How did you first find out about our office?

Newspaper? Phone Book? Insurance Company? Drive By? Other ______________

www.columbusfamilydentalcare.com? Relative/Friend ______________________

Patient Medical History

Physician's name ______________________________ Office Phone ______________________

When was your last complete physical examination? ______________________________

1. Are you in general good health at this time? .... Yes No
2. Are you under any medical treatment now? .... Yes No
3. Have you ever had any major operations? If so, what? .... Yes No
4. Have you ever had a serious accident involving head injuries? .... Yes No
5. Have you ever had any adverse response to any drugs including penicillin? .... Yes No
6. Has a physician ever diagnosed you with: A Heart Murmur or Heart Ailment? .... Yes No
7. High Blood Pressure? .... Yes No
8. Respiratory Disease? .... Yes No
9. Diabetes? .... Yes No
10. Rheumatic Fever? .... Yes No
11. Rheumatism or Arthritis? .... Yes No
12. Tumors or growths? .... Yes No
13. Any Blood Disease? .... Yes No
14. Any Liver Disease? .... Yes No
15. Any Kidney Disease? .... Yes No
16. Any Stomach or Intestinal Disease? .... Yes No
17. AIDS or a positive test for HIV? .... Yes No
18. Any type of Hepatitis? .... Yes No
19. Do you have any artificial joints or heart valves? When were they placed? .... Yes No
20. Are you taking any drugs or medications at this time? .... Yes No
21. Are you allergic to any known materials resulting in hives, asthma, eczema, etc.? .... Yes No
22. Have any wounds ever healed slowly or presented other complications? .... Yes No
23. Are you pregnant or nursing? .... Yes No
24. Do you have a history of fainting? .... Yes No

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A General Dentistry Practice

New Patient Form

Patient Dental History

25. Do you have pain in or near your ears? .... Yes No
26. Do you have any unhealed injuries or inflamed areas in or around your mouth? .... Yes No
27. Have you ever experienced any growths or sore spots in your mouth? .... Yes No
28. Does any part of your mouth hurt when your teeth are clenched? .... Yes No
29. Have you ever had local anesthetic, such as Novacaine? .... Yes No
30. Any allergic reactions to local anesthetic? .... Yes No
31. Any difficult tooth extractions in the past? .... Yes No
32. Any prolonged bleeding following extractions? .... Yes No
33. Are your teeth sensitive to cold, hot, or sweet foods or beverages? .... Yes No
34. Do your gums bleed when brushing or flossing? .... Yes No
35. Have you ever had instruction on the correct method of brushing or flossing? .... Yes No
36. Do you chew on only one side of your mouth? If so, why? .... Yes No
37. Do you have any dental complaints or problems at the present time? .... Yes No
38. Do you regularly clench or grind your teeth during the night or day? .... Yes No
39. When was your last full-mouth/panoramic x-ray taken? ______________ Where? ________________________
40. Are you happy with the way your teeth look? Do you like your smile? .... Yes No

Signature____ Date_________________________
(Patient or Parent/Guardian)