

**Patient Personal Information**

Title \_\_\_\_\_ Nickname \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
 Last, First \_\_\_\_\_ Marital Status \_\_\_\_\_ Gender \_\_\_\_\_  
 Address \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_  
 \_\_\_\_\_ Cell # \_\_\_\_\_ Drive Lic \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ Student \_\_\_\_\_ SSN \_\_\_\_\_  
 Email \_\_\_\_\_ School Name \_\_\_\_\_  
 \_\_\_\_\_ How did you hear about our practice? \_\_\_\_\_  
 Is patient responsible for paying bills?  Yes  No

**Person responsible/guarantor for paying bills**

Title \_\_\_\_\_ Nickname \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
 Last, First \_\_\_\_\_ Marital Status \_\_\_\_\_ Gender \_\_\_\_\_  
 Address \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_  
 \_\_\_\_\_ Cell # \_\_\_\_\_ Drive Lic \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ SSN \_\_\_\_\_  
 Email \_\_\_\_\_

**Dental Insurance**

Do you have **Primary** Dental Insurance?  Yes  No  
 Group No./Name \_\_\_\_\_  
 Insurance Name \_\_\_\_\_  
 Phone # \_\_\_\_\_  
 Employer Name \_\_\_\_\_  
 Subscriber Last, First \_\_\_\_\_  
 Subscriber Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Birth Date \_\_\_\_\_  
 Subscriber ID \_\_\_\_\_

Do you have **Secondary** Dental Insurance?  Yes  No  
 Group No./Name \_\_\_\_\_  
 Insurance Name \_\_\_\_\_  
 Phone # \_\_\_\_\_  
 Employer Name \_\_\_\_\_  
 Subscriber Last, First \_\_\_\_\_  
 Subscriber Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Birth Date \_\_\_\_\_  
 Subscriber ID \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Medical Alerts**

**Do You Have the Following:**

- Amoxicillin Allergy
- Aspirin or Ibuprofen Allergy
- Augmentin Allergy
- Epinephrine Sensitivity Allergy
- Erythromycin Allergy
- Clindamycin Allergy
- Codeine / Other Pain Killers Allergy
- Iodine Allergy
- Latex or Rubber Product Allergy
- Local Anesthetics Allergy
- Metals Allergy
- Penicillin Allergy
- Sedatives or Barbiturates Allergy
- Sulfa Drugs Allergy
- Other Allergy (list on Medical Questionnaire)

- Chemotherapy/Radiation
- Communication Issue
- Development Delay
- Learning Problems
- Organ Transplant
- Sensory Integration Disorder
- Wheel Chair

**EYE, EAR, NOSE, THROAT PROBLEMS**

- Canker Sores
- Cold Sores (Herpes)
- Ear Aches (Otitis)
- Frequently Dry Mouth/Sjogren
- Glaucoma
- Large Tonsils or Adenoids
- Hay Fever/Seasonal Allergies
- Hearing Impaired
- Sinus Trouble
- Vision Loss

**HEART PROBLEMS**

- Mitral Valve Prolapse
- Angina
- Chest Pain
- Congenital Heart Defects
- Congestive Heart Failure
- Coronary Artery Disease
- Heart Attack
- Heart Surgery
- Heart Damage
- Heart Murmur
- Heart Valve Replacement
- Irregular Heart Beat
- Pacemaker
- Defibrillator
- Rheumatic Fever

**LUNG PROBLEMS**

- Asthma
- Bronchitis
- Chronic Cough
- COPD

**Are You Using the Following**

- Antibiotics
- Anticoagulants/Blood Thinners
- Aspirin
- Cortisone/Prednisone
- High Blood Pressure Medication
- Insulin
- Motrin/Aleve/ Ibuprofen
- Oral Anti-Diabetic
- Nitroglycerin

**Currently Taking or Ever Taken**

- Actonel
- Aredia
- Boniva
- Fosamax
- Prolia
- Reclast
- Zometa
- Other Bisphosphonates

**Check, if applicable**

- Premedication Needed
- Alcohol/Drug Abuse
- Cancer/Tumor Growth

- Emphysema
- Pneumonia
- Reactive Airway Disease
- Shortness of Breath
- Sleep Apnea
- Tuberculosis

**VASCULAR/BLOOD PROBLEMS**

- Anemia
- Leukemia
- Excessive, Prolonged Bleeding
- High Blood Pressure
- Low Blood Pressure
- Leg Bypass Surgery

**GASTROINTESTINAL PROBLEMS**

- Acid Reflux
- Cirrhosis
- Colitis
- Crohn's Disease
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Hiatal Hernia
- Intestinal Bleeding
- Ulcers

**GENITOURINARY PROBLEMS**

- Dialysis
- Kidney Disease/Failure
- Urinary Tract Infections

**MUSCLE/BONE/SKIN PROBLEMS**

- Arthritis
- Artificial Joints
- Back Problems
- History of Skin Problems
- Joint Problems
- Muscle Problems
- Neck Problems
- Osteoporosis

**NERVOUS SYSTEM PROBLEMS**

- ADD/ADHD

- Alzheimer's Disease
- Anorexia / Bulimia
- Anxiety
- Autism Spectrum Disorder
- Bipolar Disease
- Cerebral Palsy
- Dementia
- Depression
- Epilepsy
- Fainting Spells
- Injury to Head
- Migraines
- Muscular Dystrophy
- Numb Areas
- Paralysis
- Parkinsons Disease
- Seizures
- Stroke
- Other Psychiatric Condition

**ENDOCRINE PROBLEMS**

- Diabetes Type 1
- Diabetes Type 2
- Low Blood Sugar
- Thyroid Problems

**IMMUNE SYSTEM PROBLEMS**

- AIDS/HIV
- Lupus
- Rheumatoid Arthritis

**OTHER PROBLEMS**

- Jaundice
- Liver Disease
- Measles, Mumps, Chickenpox
- Other Medical Condition

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Dental Questionnaire**

- 1. Name, Address & Phone of Previous/Referring dentist: \_\_\_\_\_
- 2. When did you last visit a dentist? \_\_\_\_\_
- 3. What was done at that time? \_\_\_\_\_
- 4. Why did you leave that dentist? \_\_\_\_\_
- 5. Date of your last cleaning \_\_\_\_\_
- 6. Date of your last exam \_\_\_\_\_
- 7. Date of your last full series of x-rays \_\_\_\_\_
- 8. Date of last cavity detection (bitewing) x-rays \_\_\_\_\_
- 9. Has any dental treatment been recommended to you that you have not done?  Yes; Describe: \_\_\_\_\_  No
- 10. Are you aware of any dental problems?  Yes; Describe: \_\_\_\_\_  No
- 11. What do you feel is the present condition of your mouth? \_\_\_\_\_
- 12. Do your gums bleed while brushing or flossing?  Yes  No
- 13. Have you ever been treated for gum disease?  Yes; what was done: \_\_\_\_\_  No
- 14. Are your teeth sensitive to any of the following:  Sweet  Cold  Heat  Pressure  Nothing
- 15. Are you happy with the appearance of your smile?  Yes  No; Explain: \_\_\_\_\_
- 16. Are you concerned with bad breath (malodor)?  Yes  No
- 17. Are you concerned with snoring or sleep apnea?  Yes  No
- 18. Are you concerned with grinding your teeth (bruxism)?  Yes  No
- 19. Are you aware of possible TMJ problems (does your jaw make noise or lock up)?  Yes  No
- 20. Have you had any injury to your teeth, jaw or face?  Yes; Describe: \_\_\_\_\_  No
- 21. Do you have dental anxiety?  Yes  No
- 22. If yes, is there anything you are aware of that helps alleviate the anxiety? \_\_\_\_\_

**Additional Comments**

Is there anything else that would be helpful for your dentist to know?  Yes  No


Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Medical Questionnaire**

- 1. Emergency Contact Name and Phone #: \_\_\_\_\_
- 2. Primary Physician Name, Address and Phone: \_\_\_\_\_
- 3. Referring Physician Name, Address and Phone: \_\_\_\_\_
- 4. Are you in good health?  Yes  No
- 5. When was your last physical examination? \_\_\_\_\_
- 6. Are you currently under care of a Physician?  Yes; Condition: \_\_\_\_\_  No
- 7. Have you had any serious illness, operation, accident or been hospitalized?  Yes; Describe: \_\_\_\_\_  No
- 8. Has there been any change in your general health in the past year?  Yes; Describe: \_\_\_\_\_  No
- 9. Are you currently taking any medication other than listed earlier, including OTC, vitamins or herbal remedies?  Yes; Please provide a list. \_\_\_\_\_  No
- 10. Have you had previous problems with general or local anesthesia?  Yes; Describe: \_\_\_\_\_  No
- 11. Do you have any allergies besides what was listed in the Patient Medical Information Section?  Yes; Describe: \_\_\_\_\_  No

**Women Only**

- 12. Are you pregnant or is there a chance you may be pregnant?  Yes- Due Date \_\_\_\_\_  No
- 13. Are you currently nursing?  Yes  No

**Family/Personal/Social History**

- 14. Mother Healthy?  Yes  No; Explain: \_\_\_\_\_
- 15. Father Healthy?  Yes  No; Explain: \_\_\_\_\_
- 16. Do you now or have you ever used:
  - Tobacco/Chew/e-cigarettes  No  Yes Frequency \_\_\_\_\_ Number of years \_\_\_\_\_ Quit Date \_\_\_\_\_
  - Alcohol  No  Yes Frequency \_\_\_\_\_ Last Drink \_\_\_\_\_ Quit Date \_\_\_\_\_
  - Recreational/Street Drugs  No  Yes Frequency \_\_\_\_\_ Number of Years \_\_\_\_\_ Quit Date \_\_\_\_\_

**Additional Comments**

<b>Additional Comments</b>

**By signing below, I certify that all of the above information is true to the best of my knowledge.**

\_\_\_\_\_  
Patient's Signature (Parent/Guardian)      Date

\_\_\_\_\_  
Dentist/Doctor's Signature      Date

**INFORMATION UPDATED**

\_\_\_\_\_  
Patient's Signature (Parent/Guardian)      Date

\_\_\_\_\_  
Dentist/Doctor's Signature      Date





**New Patient Radiograph Request Form**  
 (Send this form to your current/former dentist)

Please send my/our most current Complete Series & Bitewing Radiographs to:

**Precision Oral & Facial Surgery**  
 2717 Superior Drive Northwest, Suite B  
 Rochester, MN 55901  
 (507) 517-3871  
 (507) 847-1162

Please print first and last name(s) for ALL patients whose records need to be transferred:	Please print corresponding date(s) of birth:

\_\_\_\_\_  
 Patient/Legal Guardian Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Print Name