Patient Information Form

Today's Date_____

Patient's Name First _____ MI____Last _____Nickname _____

Address Street _____City _____State _____Zip _____

Phone Primary _____Cell _____Work _____

Date of Birth _____**Social Security Number** _____

Employer _____Phone _____

Marital Status ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

**** In case of emergencies, who should be notified?** _____

Relationship to Patient _____Primary Phone _____

Is patient a minor ☐Yes ☐No **Full Time Student** ☐Yes ☐No Name of School _____

Name of Responsible Party First _____Last _____

Relationship to Patient ☐Parent ☐Guardian ☐Other: _____

Primary Custody:

☐Both Parents ☐Mom ☐Dad ☐Shared Custody ☐ Other: _____

Phone Number *(if different from above)* _____

Communication Preferences

What is your preferred method of communication? *(please check all that apply)*

☐ **Phone call** – best number to reach you: _____

☐ **Text message** – best number to text you: _____

☐ **Email** – please provide your email address: _____

How did you hear about us?

☐One of our valued patients (name of patient) _____

☐Facebook ☐Our Website ☐Billboard

☐Insurance Network ☐Internet Search ☐Bayou Life

☐Our Location ☐Other: _____

Dental History Form

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

Date of last radiographs (xrays) and exam _____

Date of last hygiene continuing care appointment *(cleaning or periodontal maintenance)* _____

Former Dentist _____ Phone _____

If you left your previous dentist, what are the reasons? _____

_____

☐Yes ☐No **Have you had problems with prior dental treatment?**
If yes, what were they? _____

☐Yes ☐No **Are you experiencing any pain now?**
If yes, please describe _____

☐Yes ☐No **Have you ever been pre-medicated for dental treatment?**
If yes, why? _____

☐Yes ☐No **Have you been anxious about having dental treatment? If yes, would you be comfortable sharing why?**
_____

☐Yes ☐No **Would you like to discuss this concern with the doctor to learn about your relaxation options?**

What concerns do you currently have with your oral health or smile? *(please check all that apply)*

☐Jaw joint pain
☐Clenching or grinding of teeth
☐Discolored teeth
☐Crowding/crooked teeth
☐Missing teeth
☐Spaces in between teeth
☐Loose tooth/teeth
☐Tooth shape/size
☐Unhappy with appearance of teeth
☐Overbite
☐Underbite
☐Uncomfortable bite
☐Old fillings *(gold or silver)*
☐Old crowns
☐Speech problems
☐Too much gum tissue when I smile
☐Tooth sensitivity to hot/cold
☐Tooth sensitivity to biting
☐Tooth sensitivity to sweets
☐Food gets caught between teeth
☐Difficulty chewing
☐Bad breath
☐Other: _____

☐Yes ☐No **Have you ever had orthodontic treatment?** If yes, when? _____

☐Yes ☐No **Have you ever had periodontal treatment such as deep cleanings, root planning, or periodontal surgery?**
If yes, what kind of treatment and when? _____

Are you interested in learning about the following? *(please check all that apply)*

☐Teeth Whitening
☐Orthodontic treatment
☐Tooth replacement options
☐Botox for clenching and grinding
☐Tooth colored fillings
☐Dental implants
☐Oral hygiene care for infants/toddlers
☐Cosmetic Botox
☐At home oral hygiene care
☐Periodontal prevention/treatment
☐Juvederm filler around mouth
☐Other: _____

Health History Form

Preferred Pharmacy _____

Name of Primary Physician _____ Phone _____

☐Yes ☐No **Have you been admitted to a hospital or needed emergency care during the past two years?**

If yes, please explain _____

☐Yes ☐No **Do you have any allergies?**

☐Penicillin ☐Latex ☐Other: _____

Tobacco Use: ☐**Smokeless** How long? _____

☐**Smoking** How long? _____

☐**Vaping** How long? _____

☐Yes ☐No **Are you currently taking any medications?**

☐Yes ☐No **Are you taking a blood thinner?** If so, which kind? _____

**** Please list all other medications or provide a separate complete list** _____

_____

_____

Do you currently or have you ever had any of the following? *(please check all that apply)*

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Defibrillator
- ☐ Ehlers Danlos
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting Condition
- ☐ Fibromyalgia
- ☐ Head Trauma
- ☐ Heart Valve Condition
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Myasthenia Gravis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Sickle Cell Anemia
- ☐ Sjogrens Sydrome
- ☐ Postural Orthostatic Tachicardia
- ☐ Heart Attack
  Date:
- ☐ Stroke
  Date:
- ☐ Heart Surgery
  Date:
- ☐ Head or Neck Radiation
  Date:
- ☐ Artificial Joint
  Date:

Are you currently pregnant? ☐No ☐Yes - Due Date: _____

Do you have any health concerns that need further clarification? ☐Yes ☐No

If yes, please explain _____

_____

Notice of Privacy Practice

☐ I acknowledge that I have received a copy of the South Roots Dental of Louisiana Notice of Privacy Practice to review.

Financial Policy

☐ I have read the Southern Roots Dental of Louisiana Financial Policy, and I understand and agree to this policy.

Signature of Patient or Responsible Party: _____ Date: _____