Robert M. Spaulding, DDS

PERSONALIZED & COMFORTABLE DENTAL CARE

PATIENT INFORMATION RECORD

Date: _____

Whom may we thank for referring you to our office? _____

Patients Name _____ Birthdate _____

Mailing Address _____ City _____ State _____ Zip _____

Physical Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Social Security # _____ Drivers License # _____ Email _____

Student: Full Time ❒ Part Time ❒ School Name: _____

EMPLOYMENT INFORMATION

Employer _____ Employee _____

Work Address _____ Occupation _____

RESPONSIBLE PARTY INFORMATION

(Complete only if other than self)

Responsible Party Name: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Birthdate _____

Social Security # _____ Relationship to Patient _____

INSURANCE INFORMATION

Dental Coverage: Yes ❒ No ❒

Primary Dental Insurance information

Insurance Co. Name _____

Address _____

Telephone _____

Group # _____

Insured Name _____

Relationship to Patient _____

Soc.Sec # _____

Date of Birth _____ I.D.# _____

Employer _____

Secondary Dental Insurance information

Insurance Co. Name _____

Address _____

Telephone _____

Group # _____

Insured Name _____

Relationship to Patient _____

Soc.Sec # _____

Date of Birth _____ I.D.# _____

Employer _____

PATIENT HISTORY

Please answer all questions

MEDICAL HISTORY

Are you under a physician's care now? YES ❒ NO ❒ Reason _____

Have you been hospitalized or had a serious illness within the past 5 years? _____

Date of last medical examination: _____

Physician's Name _____ Phone _____

Do you have or have you ever had any of the following:

	YES	NO
Heart Disease	❒	❒
Shortness of breath with limited activity or when sitting	❒	❒
Chest pain or angina pectoris	❒	❒
Heart attack	❒	❒
Rheumatic fever or rheumatic heart disease	❒	❒
Heart murmur	❒	❒
Heart defect from birth	❒	❒
High blood pressure	❒	❒
Stroke	❒	❒
Fainting spells, convulsions, or epilepsy	❒	❒
Nervous breakdown or emotional problems	❒	❒
Lung disease (T.B., asthma, emphysema or other)	❒	❒
Joint surgery or a prosthetic joint replacement	❒	❒
Acquired Immune Deficiency Syndrome	❒	❒
Latex allergy	❒	❒

	YES	NO
Liver disease (hepatitis, jaundice, cirrhosis or other)	❒	❒
Kidney Disease	❒	❒
Diabetes	❒	❒
Prolonged bleeding following injuries or surgery	❒	❒
Blood disorder (anemia or other)	❒	❒
Venereal disease (syphilis, gonorrhea)	❒	❒
Arthritis	❒	❒
X-ray treatments or radiation therapy	❒	❒
Treatment for a tumor or growth	❒	❒
Do you have any limitations regarding activity or diet?	❒	❒
If so, what? _____		
Are you pregnant?	❒	❒
Month: _____		
Have you ever had any complications with past pregnancies	❒	❒

Doctor's Notes: _____

_____

Please list any drugs (including bisphosphonates i.e. Boniva, Fosamax) currently being taken: _____

_____

_____

_____

Do you smoke? Yes ❒ No ❒ How much? _____ How Long? _____

Have you become sick from, shown any allergy to, or been told not to take any of the following?

	YES	NO
Penicillin or other antibiotics	❒	❒
Aspirin, codeine or other pain medications	❒	❒
Novocaine, Xylocaine, or other anesthetics	❒	❒

Other medications: _____

_____

Doctor's Notes: _____

_____

_____

_____

Initial Evaluation Date _____

Baseline Blood Pressure _____ / _____

Baseline Pulse Rate _____ /min_____

Update Info: _____

_____

_____

_____

DENTAL HISTORY

PRESENT SYMPTOMS:

Why have you come to this office? _____

_____

Are you in pain? YES ❒ NO ❒ If so, where? _____

_____

Have you noticed any of the following?

	YES/NO			YES/NO	
Teeth tender to chew on	❒	❒	Recurring sore in or around the mouth	❒	❒
Discomfort in face, head, neck	❒	❒	Jaw clicking or popping	❒	❒
Food caught between teeth	❒	❒	Sensitivity to hot or cold	❒	❒
Bleeding or sore gums	❒	❒	Swelling, lumps in mouth	❒	❒
Sensitivity to sweets	❒	❒	Unpleasant odor/taste	❒	❒
Difficulty Swallowing	❒	❒	Frequent headaches	❒	❒
Awareness of clinching or grinding	❒	❒			
Are you dissatisfied with your teeth and their appearance	❒	❒			

Please Explain _____

PAST DENTAL HISTORY:

Previous Dentist(s) _____, were X-Rays taken? YES ❒ NO ❒

Date of last visit _____ Date of last cleaning _____

Have you had any problems with previous dental treatment? YES ❒ NO ❒

Do you consider yourself a fearful dental patient? YES ❒ NO ❒

Have you ever had a tooth extracted? YES ❒ NO ❒ Any complication? _____

Have you ever had teeth replaced with dentures/partials or bridges? YES ❒ NO ❒

Have you ever been told you have pyorrhea/gum disease? YES ❒ NO ❒

Have you ever had orthodontic treatment? (braces) YES ❒ NO ❒ When? _____

In case of an emergency, who should we contact?

Name: _____

Full Address: _____

Phone Number: _____ Relationship: _____

The information above is correct to the best of my knowledge. I give my consent to have the necessary treatment recommended for my benefit (or my minor) only after it has been mutually approved. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless financial arrangements have been made.

Date _____ Signature _____