GERIATRIC DENTAL GROUP

A CHARITABLE NON PROFIT ORGANIZATION

GERIATRIC DENTAL GROUP
NEW PATIENT EXAM FORM

PATIENT NAME _____ **TODAY'S DATE** _____
HOME ADDRESS _____ **BIRTHDATE** _____
_____ **HOME PHONE** _____
CITY _____ **ST** _____ **ZIP** _____ **CELL PHONE** _____

PATIENT NAME

Dental Insurance?_____

PATIENT MEDICAL HISTORY

PHYSICAN _____ **OFFICE PHONE** _____ **DATE OF LAST EXAM** _____

	Yes	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any Medication(s) Incliding non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. do you use tobacco?	☐	☐
5. Do you use alcohol	☐	☐
if yes how often? _____		
6. Do you use drugs?	☐	☐

7. Are you allergic to or have you had any reactions to the folloeing?

Yes	NO		Yes	NO		Yes	NO	
☐	☐	Local anesthetics (eg. novocaine)	☐	☐	Barbiturates	☐	☐	Aspirin
☐	☐	Penicillin	☐	☐	Sedatives	☐	☐	Other
☐	☐	Sulfa drugs	☐	☐	Iodine			
☐	☐	Other antibiotics						

8. Do you have or have you had any of the following?

Yes	NO		Yes	NO		Yes	NO		Yes	NO	
☐	☐	**High Blood Pressure**	☐	☐	**AIDS or HIV Infection**	☐	☐	**Cancer**	☐	☐	**Stroke**
☐	☐	**Heart Attack**	☐	☐	**Thyoid Problem**	☐	☐	**Arthritis**	☐	☐	**Hay Fever / Allergies**
☐	☐	**Rheumatic fever**	☐	☐	**Heart Disease**	☐	☐	**Joint Replacement or Implent**	☐	☐	**Tuberculosis**
☐	☐	**Swollen Ankles**	☐	☐	**Cardiac Pacemaker**	☐	☐	**Hepatitis / Jaundice**	☐	☐	**Radiation Therapy**
☐	☐	**Fainting / Seizures**	☐	☐	**Heart Murmur**	☐	☐	**Oral Herpes**	☐	☐	**Glaucoma**
☐	☐	**Asthma**	☐	☐	**Angina**	☐	☐	**Stomach Troubles / Ulcers**	☐	☐	**Recent Weight Loss**
☐	☐	**Low Blood Pressure**	☐	☐	**Frequently Tired**	☐	☐	**Psychiatric Treatment**	☐	☐	**Liver Disease**
☐	☐	**Diabetes**	☐	☐	**Anemia**	☐	☐	**Chest Pains**	☐	☐	**Respiratory Problems**
☐	☐	**Kidney Disease**	☐	☐	**Emphysema**	☐	☐	**Easily Winded**	☐	☐	**Other** _____

PATIENT DENTAL HISTORY

	Yes	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?	☐	☐
a) Clicking?	☐	☐
b) Pain (joint, ear side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or gring your teeth?	☐	☐
10. Do you bite your lips or cheeks frequenlty?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic work?	☐	☐
13. Have you ever had prolomged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

I certify that I have read and understand the above Information. To the best of my knowledge, the above questions have been accurately answered
I understand that providing Incorrect Information can be dangerous to my health.

SIGNATURE X _____ _____

PATIENT, PARENT OR GUARDIAN **DATE**