



GERIATRIC DENTAL GROUP

A CHARITABLE NON PROFIT ORGANIZATION

GERIATRIC DENTAL GROUP
NEW PATIENT EXAM FORM

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

PATIENT NAME

Dental Insurance?, PATIENT MEDICAL HISTORY, PHYSICIAN, OFFICE PHONE, DATE OF LAST EXAM

- 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) Including non-prescription medicine?
4. Do you use tobacco?
5. Do you use alcohol
6. Do you use drugs?

- 7. Are you allergic to or have you had any reactions to the following?
Local anesthetics (eg. novocaine)
Penicillin
Sulfa drugs
Other antibiotics
Barbiturates
Sedatives
Iodine
Aspirin
Other

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

- High Blood Pressure
Heart Attack
Rheumatic fever
Swollen Ankles
Fainting / Seizures
Asthma
Low Blood Pressure
Diabetes
Kidney Disease

- AIDS or HIV Infection
Thyroid Problem
Heart Disease
Cardiac Pacemaker
Heart Murmur
Angina
Frequently Tired
Anemia
Emphysema

- Cancer
Arthritis
Joint Replacement or Implant
Hepatitis / Jaundice
Oral Herpes
Stomach Troubles / Ulcers
Psychiatric Treatment
Chest Pains
Easily Winded

- Stroke
Hay Fever / Allergies
Tuberculosis
Radiation Therapy
Glaucoma
Recent Weight Loss
Liver Disease
Respiratory Problems
Other

PATIENT DENTAL HISTORY

- 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 grind your teeth?
10. Do you bite your lips or cheeks frequently?
11. Have you ever had any difficult extractions in the past?
12. Have you had any orthodontic work?
13. Have you ever had prolonged 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