ROCKCASTLE
FAMILY DENTAL CENTER

Patient name (last, first middle): _____
(*Legal guardian's name, if patient is a minor*: _____)

Date of birth: _____ **Social security number:** _____

Primary phone number: _____ **Secondary phone number**: _____
Email address: _____

Street address: _____
City: _____ **State:** _____ **Zip:** _____

Occupation: _____
Employer: _____
How did you hear about us? _____

Emergency contact: _____
Relationship: _____
Phone number: _____

Dental information

For the following, please circle all that apply to you.

Gums bleed when brushing/flossing.
Teeth are sensitive to hot/cold.
Clench and/or grind teeth.
Drink well water.
Have dry mouth.
Have had serious facial trauma/injury.

When was your last dental treatment? _____
What was completed at that time? _____
What is your main concern today?: _____

Medical information

Name of primary care physician: _____
Address of physician: _____
Phone number of physician: _____
Preferred pharmacy: _____

Have you been hospitalized within the past year?: *yes or no*
If yes, please explain? _____

Please list all previous surgeries:

_____
_____

Please list all medications that you are currently taking. Include prescriptions and over the counter medications:

_____
_____

Please list all known allergies:

_____

Do you use recreational drugs?: *Yes or no*
Are you currently, or have you ever been, treated for drug addiction or dependence? *Yes or no*
Do you use tobacco? *Yes or no*
If yes, which type, and how often?:_____
Do you drink alcohol? *Yes or no*
If yes, how often?:_____

*Are you currently being treated for osteoporosis?: *Yes or no*
*Have you ever taken, or had an infusion of, a ***BISPHOSPHONATE***? (example: Zometa, Fosamax, Boniva, etc.) *Yes or no*

Please circle all of the diseases or problems listed below that currently apply or have ever applied to you:

Artificial heart valve
Congenital heart defect
Heart disease
Stroke (please provide date_____)
Mitral valve prolapse
Angina/chest pain
Hemophilia or bleeding disorder
Arthritis
Asthma
Sinus trouble
Tuberculosis
Radiation treatment
Diabetes Type I or Type II
Acid reflux/heartburn
Hypothyroidism
Glaucoma
Epilepsy/seizures
Kidney disease

Joint replacement
Endocarditis
Heart attack (please provide date_____)
High blood pressure
Pacemaker
Anemia
AIDS/HIV
Autoimmune disease: _____
Emphysema
COPD
Cancer/Chemotherapy (please provide date_____)
Migraines/severe headaches
Gastrointestinal disease
Gastric ulcers
Hyperthyroidism
Liver disease
Neurological disorders
**Taking blood thinners*

Please list all other diseases/problems that apply to you that are not listed above:

Women only: Are you pregnant, or think you may be pregnant? *Yes or no*
If yes, how many weeks? _____

I certify that I have read all of the above and the information I have provided is accurate. I acknowledge that providing a truthful medical history is important for my dentist to treat me. I acknowledge that I will not hold my dentist, or any other staff member, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient/guardian signature Date

Dentist signature Date