FAMILY DENTAL ASSOCIATES, PLLC

Perry M. Whites, D.M.D. **Adam W. Hodges, D.M.D.**

Name:_____ Address:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Work Phone:_____ Cell Phone:_____ Sex (M/F)_____Marital Status_____

Birthdate:_____ Social Sec.#_____ Driv. Lic.#:_____

Name of Responsible Party:_____
Social Security #_____DOB:_____
Billing Address:_____

Insurance (Y/N)_____ Employer Name:_____ Phone:_____
Address:_____ City:_____ State:_____ Zip:_____

Insurance Company Name: _____Phone:_____

Referred By:_____

Does Your Medical History Include Any Of The Following:

1. Are you allergic to penicillin? _____YES____NO
2. Do you have any other allergies? _____YES____NO
3. Do you have high blood pressure? _____YES____NO
4. Have you ever had a heart attack? A Pacemaker? _____YES____NO
5. Do you have a heart murmur? _____YES____NO
6. Do you have mitral valve prolapse? _____YES____NO
7. Do you have any other heart problems? _____YES____NO
8. Have you ever had a total hip, knee or shoulder replacement? _____YES____NO
9. Are you a diabetic? _____YES____NO
10. Do you have asthma? _____YES____NO
11. Do you have Epilepsy? _____YES____NO
12. Do you have tuberculosis? _____YES____NO
13. Do you have sleep disorder? _____YES____NO
14. Do you snore? _____YES____NO
15. Have you ever had hepatitis? _____YES____NO
16. Do you have AIDS? _____YES____NO
17. Have you ever had a rheumatic fever? _____YES____NO
18. Is there any other condition we should be aware of? _____YES____NO
19. Do you have any sores or ulcerated areas in your mouth? _____YES____NO
20. Do your gums bleed when you brush or floss? _____YES____NO
21. Have you ever had any reaction to novacaine anesthetics? _____YES____NO
22. Have you ever had a tooth extracted? _____YES____NO
23. Did you bleed excessively? _____YES____NO
24. Do you have dry mouth? _____YES____NO
25. Have you had any periodontal (gum) treatments? _____YES____NO
26. Have you ever had orthodontic (braces) treatment? _____YES____NO
27. Have you ever had a serious injury to your head or mouth? _____YES____NO
28. Are you taking or scheduled to begin taking an antiresorptive agent like Fosamax, Actonel,Atelvia, Bonvia, Reclast, Prolia for osteoporosis or Paget's disease. _____YES____NO
29. Do you use tobacco (smoking, snuff, chew, bidis) _____YES____NO
30. Are you interested in quiting? _____YES____NO
31. Do you have any teeth hurting you now? _____YES____NO
32. Do you have any dental problems you would like to discuss? _____YES____NO

33. Are you in general good health? _____YES____NO
34. Are you pregnant? _____YES____NO
35. Have you or any family member been seen at this office before? _____YES____NO

36. List the drugs you are presently taking_____

37. Pharmacy Name:_____

38. Family Doctor's Name:_____

25. In case of emergency, Notify:_____Phone:_____

Patient Signature:_____Date:_____