LINCOLNFAMILYDENTISTRY.COM

NSD NorthStar Dental — A healthy smile, for a healthy life.

coddington dental

SPD SouthPointe Dental — gentle — A gentle approach to dentistry

PATIENT INFORMATION

Name_____ SS#_____
Address_____ Email_____
City_____ State_____ Zip_____ Home Phone_____
DOB_____ Sex ___M___F Cell Phone_____
_Single _Married _Divorced _Other How did you hear about our office?_____
Employer_____ Employer Phone_____
Spouse's Name_____ Spouse's Employer_____
How would you prefer we contact you? Call_____ Email_____ Text_____

DENTAL INSURANCE

Name of Policy Holder_____ Relation to Patient_____
DOB_____ SS#_____ Employer_____

Handle My Dental Needs With Care

	Yes	No
Are you afraid of the Dentist?	O	O
Do you like your smile?	O	O
Do your gums bleed when you brush or floss?	O	O
Are your teeth sensitive to cold, hot, or pressure?	O	O
Do you drink soda-pop?	O	O
Do you floss on a daily basis?	O	O
Does your food or floss catch between your teeth?	O	O
Is your mouth dry?	O	O
Have you had any periodontal (gum) treatments?	O	O
Have you ever had orthodontics (braces) treatment?	O	O
Have you had any problems associated with previous dental treatment?	O	O
Are you experiencing any dental discomfort?	O	O

	Yes	No
Do you have earaches or neck pains?	O	O
Do you have any clicking, or discomfort in the jaw?	O	O
Do you grind or clinch your teeth?	O	O
Do you have sores or ulcers in your mouth?	O	O
Do you wear dentures or partials?	O	O
Do you participate in active recreational activities?	O	O
Have you ever had a serious injury to your head or mouth?	O	O
Do you gag easily?	O	O
Is pain relief is a top priority?	O	O
Are you afraid of shots?	O	O
Would you like your teeth to be whiter?	O	O
Would you be interested in a complimentary cosmetic evaluation of your teeth?	O	O
When was you last dental visit?		

Please choose only one of the following answers below that you feel is most important to you:
I believe dental health is important for the following reason:
a) To be able to eat & drink b) To have an attractive smile c) For overall good health d) Not to have dental pain

Health History

Physician's Name_____ Date of last visit_____

Please indicate if you **have** or **have had** any of the following:

___AIDS/HIV
___Allergy
___Anemia
___Artificial Heart Valve
___Artificial Joint
___Asthma
___Bleeding Problems
___Blood Transfusion
___Cancer
___Chemotherapy
___Cold Sores
___Diabetes
___Emphysema
___Epilepsy or convulsions
___Fainting Spells /Seizures
___Family History of Malignant Hyperthermia
___Fever Blisters
___Glaucoma
___Heart Defect or Murmur
___High Blood Pressure
___Hepatitis A (infectious)
___Hepatitis B (serum)
___Herpes
___Heart Trouble/ Attack
___Immune System Disorder
___Kidney Trouble
___Prolapsed Mitral Valve
___Radiation Treatment
___Rheumatic Heart Disease
___Pacemaker
___Sinus Trouble
___Stroke
___Taken Cortisone in Past Year
___Tuberculosis
___Ulcers

Do you smoke?
Yes No

Other_____

Medications

List any medications you are currently taking and the correlating diagnosis:

_____
_____
_____
_____

Allergies

____Aspirin
____Codeine
____Local Anesthetics
____Penicillin
____Acrylic
____Latex/ Rubber
____Sulfa Drugs
____Metals

Other allergies: _____
_____

We are pleased to welcome you to our practice!!! _____
Signature of Parent/Guardian