Fairlawn Family Dental

Kayla Mullins, DDS

Patient Information Date:_____

Patient Full name _____ Preferred Name_____

If Minor Parent/Guardian Name _____

Home Phone: _____ Cell Phone:_____ Preferred Contact Method:_____

DOB_____ SS# _____

Address _____ City_____ State_____ Zip_____

Mailing Address (if different)_____ City_____ State _____ Zip_____

Single ____ Married_____ Widowed _____ Divorced_____

Employer _____ Position _____

Work Address _____ Work Phone_____

Emergency Contact _____ Phone Number _____

Relationship to Patient _____

How did you hear about our office? _____

Billing and Insurance Information

Person responsible for account _____ (must be 21)

Relationship _____ Employer _____

Signature _____

Primary Dental Insurance _____ Subscriber _____ Employer _____

SS# of insurance subscriber _____ DOB of subscriber_____ Group Number _____

Secondary Insurance _____ Subscriber _____ Employer _____

SS# secondary subscriber _____ DOB_____ Group Number _____

PLEASE PROVIDE INSURANCE CARDS AND DRIVERS LICENSE TO COPY FOR OUR RECORDS

Medical History

Name of Personal Physician _____ Date and reason last appointment _____

Physician Phone Number _____ Please list specialists you see regularly _____

Signature giving permission to contact physician to discuss any health concerns _____

Have you ever been hospitalized for a major illness ( ) YES ( ) NO

If yes when and what for? _____

Please indicate of you have any of the following conditions

___ Cancer or tumor

___ Heart ailment or angina

___ Heart murmur, mitral valve prolapse, or other heart defect

___ Artificial joint or valve
Date placed _____

___ High Blood Pressure

___ Low Blood Pressure

___ Allergies

___ Anemia or other blood disorders

___ Epilepsy or history of seizures
Date of last seizure _____

____ Diabetes
Most recent A1C _____

___ History of Excessive Bleeding

___ Blood Transfusion

___ Hepatitis or other Liver Disease

___ Neurologic Condition

___ History of cold sores/herpetic lesions

___ Migraines or frequent headaches

___ Stroke

___ Thyroid Problem

___ Radiation Treatment

___ Rheumatic fever or rheumatic heart disease

___ Heart Attack or Heart Surgery
Date _____

___ Pacemaker
Date placed _____

___ Tuberculosis

___ Asthma

___ Emphysema

___ Pneumonia

___ Difficulty Breathing

___ Fainting Spells

___ Arthritis

___ Kidney Disease

___ Alcohol or drug abuse, current or previous

___ Hay fever or other sinus trouble

___ Depression

___ Back/Neck condition affecting ability to sit in dental chair

___ History of trauma to face/teeth

___ Stomach ulcer

Please list any medications or materials you are allergic to or have had a negative reaction to in the past

_____ ( )Latex ( ) Anesthesia

Do you use tobacco regularly ( )YES ( )NO If yes please list types of tobacco and length of use, and amount per day

_____

Please list all medications (prescription AND over the counter) and reason/condition

_____
_____
_____

Have you taken a steroid drug in the past 2 years? _____ Date steroid was taken _____

Women:

Is there any chance you may be pregnant? ( )YES ( )NO If yes, expected delivery date _____

Are you taking hormones or other contraceptives (birth control)? ( )YES ( )NO

Are you currently breastfeeding? ( )YES ( )NO

Please add any other information we should be informed about concerning your health _____

_____

Dental History

When was your last dental visit? _____ Reason for last dental visit? _____

Do you have your teeth professionally cleaned regularly? If so date of last cleaning _____

How many times a day do you brush? _____ Type of toothbrush _____

How often do you floss? _____ How many soft drinks do you drink daily? _____

In your home do you have city/county water or well water? _____

Please list all previous dental treatments you are aware of _____

_____

Please indicate if you have any of the following

___ Fear/apprehension about dental treatment
___ Sensitive gag reflex
___ Wear denture and/or partial
___ Chew food only on one side of mouth
___ Gums bleed easily
___ Slow healing sores in or around your mouth
___ Desire to save your teeth
___ Clench or grind teeth
___ Pain when chewing or biting
___ Teeth sensitive to hot
___ Dry Mouth
___ Problems with previous dental treatment
___ Food catching between your teeth
___ Difficulty chewing or swallowing food
___ Avoid brushing parts of mouth due to pain
___ Swollen or tender gums
___ Dissatisfied with appearance of teeth
___ Clicking or popping in jaw when open/close mouth
___ Jaw sometimes being stuck in open/close position
___ Commonly hold toothpick, pipe, other object in teeth
___ Teeth sensitive to cold
___ Participate in recreational activities that could potentially cause damage to your teeth

If you have ever had any trauma to the head that affected your teeth please describe _____

_____

Please add any other information we should know about your previous dental work or current dental problems

_____

Office Policy on Broken Appointments

Please allow **24 HOUR** notice if you are unable to keep your appointment with our office. Not showing up to an appointment or less than 24 hour notice of an appointment cancellation will result in a failed appoint being noted on your record. You may bring a written excuse/proof to show there was a legitimate reason for the failed appointment and it will be removed from your record. After 3 failed appointments you will be sent a termination letter ending your ability to be treated for non-emergencies at this office, at that time we will gladly provide you with copies of your records that can be taken to another dental office.

Your signature on the line below indicates:

The information provided is, to the best of my knowledge, correct. I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my medical status or medications at once. I authorize Dr. Mullins to use any photographs or radiographic images for promotional or educational purposes. I also authorize the release of information from my medical doctor/dentist to Dr. Mullins as needed.

Signature _____ Date _____