# Welcome

*to*


**Office of:**
**HEATHER RHOADS PFEFFERLE, DDS**

*Please take a moment to answer the following questions so we can better assist you with your dental needs*

## Patient Information

Date_____ Name (Last, First, MI)_____

Address_____ SS#_____
(Street) (City) (State) (Zip)

Home Phone_____ Cell Phone_____ Email Address_____

***Please indicate appointment confirmation preference(s): Home Phone Call ☐ | Cell Phone Call ☐ | Cell Phone Text ☐ | Email ☐***

Birthdate_____ Sex: M☐F☐Marital Status_____ Is Patient a Minor? Y☐N☐

(If Patient is a Minor) Legal Guardian Name_____ Guardian Phone_____

Employer/School_____ Occupation_____

Employer/School Address_____ Phone_____

Spouse's Name_____ SS#_____ Birthdate_____ Employer_____

Hobbies/Interests_____ Whom may we thank for referring you_____

EMERGENCY CONTACT NAME _____ Phone_____

## Dental Insurance

Who is responsible for this account_____ Relationship to patient_____

Insurance Co._____ Subscriber ID#_____Group #_____

Is patient covered by additional Insurance? Y☐N☐

Subscriber's Name_____ SS#_____ Birthdate_____

Relationship to Patient_____ Subscriber's Employer_____

Insurance Co._____ Subscriber ID#_____Group #_____

**Please Continue on Next Page**

## Dental History

Reason for today's visit_____ Last Dental Visit_____

Previous Dentist's Name_____ City/State_____

Please mark "yes" or "no" to indicate if you have or have had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Bad breath | ☐ Yes | ☐ No | Loose teeth or broken fillings | ☐ Yes | ☐ No |
| Bleeding of gums | ☐ Yes | ☐ No | Mouth breathing | ☐ Yes | ☐ No |
| Blisters on lips or mouth | ☐ Yes | ☐ No | Orthodontic treatment | ☐ Yes | ☐ No |
| Burning sensation on tongue | ☐ Yes | ☐ No | Pain around ear | ☐ Yes | ☐ No |
| Chew on one side of mouth | ☐ Yes | ☐ No | Periodontal treatment | ☐ Yes | ☐ No |
| Cigarette, cigar, or pipe smoking | ☐ Yes | ☐ No | Sensitivity to cold | ☐ Yes | ☐ No |
| Clicking or popping jaw | ☐ Yes | ☐ No | Sensitivity to heat | ☐ Yes | ☐ No |
| Dry mouth | ☐ Yes | ☐ No | Sensitivity to sweets | ☐ Yes | ☐ No |
| Fingernail biting | ☐ Yes | ☐ No | Sensitivity when biting | ☐ Yes | ☐ No |
| Food collection between teeth | ☐ Yes | ☐ No | Sores or growths in your mouth | ☐ Yes | ☐ No |
| Grinding teeth | ☐ Yes | ☐ No | How often do you brush_____ | | |
| Gums swollen or tender | ☐ Yes | ☐ No | How often do you floss_____ | | |
| Jaw pain or tenderness | ☐ Yes | ☐ No | If you could, what would you change about your smile? | | |
| Lip or cheek biting | ☐ Yes | ☐ No | _____ | | |

## Medical History

Physician's Name_____ Date of last exam_____

Have you ever taken any of the group of drugs referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin, Pondimin, and Redux? ☐ Yes ☐ No

Have you ever been given I.V. or taken oral bisphosphonate drugs for bone loss, such as Fosamax, Boniva, Actonel, Zometa, or Aclasta? ☐ Yes ☐ No

Place a mark on "yes" or "no" if you have, or have had, any of the following:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐Yes | ☐No | Epilepsy | ☐Yes | ☐No | Respiratory Disease | ☐Yes | ☐No |
| Anemia | ☐Yes | ☐No | Fainting or dizziness | ☐Yes | ☐No | Rheumatic Fever | ☐Yes | ☐No |
| Arthritis, Rheumatism | ☐Yes | ☐No | Glaucoma | ☐Yes | ☐No | Scarlet Fever | ☐Yes | ☐No |
| Artificial Heart Valve | ☐Yes | ☐No | Headaches | ☐Yes | ☐No | Shortness of Breath | ☐Yes | ☐No |
| Artificial Joints | ☐Yes | ☐No | Heart Murmur | ☐Yes | ☐No | Sinus Trouble | ☐Yes | ☐No |
| Asthma | ☐Yes | ☐No | Heart Problems | ☐Yes | ☐No | Skin Rash | ☐Yes | ☐No |
| Back Problems | ☐Yes | ☐No | Hepatitis, type_____ | ☐Yes | ☐No | Special Diet | ☐Yes | ☐No |
| Bleeding abnormally, with extractions or surgery | ☐Yes | ☐No | Herpes | ☐Yes | ☐No | Stroke | ☐Yes | ☐No |
| | | | High Blood Pressure | ☐Yes | ☐No | Swollen Feet or Ankles | ☐Yes | ☐No |
| Blood Disease | ☐Yes | ☐No | Jaundice | ☐Yes | ☐No | Swollen Neck Glands | ☐Yes | ☐No |
| Cancer | ☐Yes | ☐No | Jaw Pain | ☐Yes | ☐No | Thyroid Problems | ☐Yes | ☐No |
| Chemical Dependency | ☐Yes | ☐No | Kidney Disease | ☐Yes | ☐No | Tonsillitis | ☐Yes | ☐No |
| Chemotherapy | ☐Yes | ☐No | Liver Disease | ☐Yes | ☐No | Tuberculosis | ☐Yes | ☐No |
| Circulatory Problems | ☐Yes | ☐No | Low Blood Pressure | ☐Yes | ☐No | Tumor or growth in head or neck | ☐Yes | ☐No |
| Congenital Heart Lesions | ☐Yes | ☐No | Mitral Valve Prolapse | ☐Yes | ☐No | | | |
| Cortisone Treatments | ☐Yes | ☐No | Nervous Problems | ☐Yes | ☐No | Ulcer | ☐Yes | ☐No |
| Cough, persistent or bloody | ☐Yes | ☐No | Pacemaker | ☐Yes | ☐No | Venereal Disease | ☐Yes | ☐No |
| Diabetes | ☐Yes | ☐No | Psychiatric Care | ☐Yes | ☐No | Weight Loss, unexplained | ☐Yes | ☐No |
| Emphysema | ☐Yes | ☐No | Radiation Treatment | ☐Yes | ☐No | Do you wear contact lenses? | ☐Yes | ☐No |

**Women:**

| | | | |
|---|---|---|---|
| Are you pregnant? | ☐Yes | ☐No | Due Date_____ |
| Are you nursing? | ☐Yes | ☐No | |
| Taking birth control pills? | ☐Yes | ☐No | |

*Please Continue on Next Page*

## Allergies

Please circle any allergies: ☐Aspirin ☐Barbituates (sleeping pills) ☐Codeine ☐Iodine ☐Latex
☐None Known ☐Local Anesthetic ☐Penicillin ☐Sulfa Other_____

## Medications

Please list any medications you are currently taking, complete with dosage, duration, and corresponding diagnosis:

_____

_____

_____

If you are filling this out on-line please stop here, print, and bring in with you for your first appointment, thank you.

*****Please leave below for office use and continue on the back, thank you*****

## Medical Updates (to be filled in at future appointments)

Any new conditions? ☐Yes ☐No If so, what?_____
New medications_____

Patient Signature_____ Date_____

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Any new conditions? ☐Yes ☐No If so, what?_____
New medications_____

Patient Signature_____ Date_____

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****Office Notes****