NORTHWEST FAMILY DENTAL
6708 Azle Ave Suite 100
Fort Worth, Texas 76135
817-237-3232

Patient Information

Date:______/_____/________
First Name:___________________________Last Name:____Middle Initial:______
Address:____CIty:____________________________ State/Zip_________________
Home Phone:(_______)_______-_________ Cell Phone: (______)_______-_________
Sex : ☐ Male ☐ Female Marital Status:: ☐ Married ☐ single ☐ Divorced ☐ Separated ☐ widowed
Birth Date:_______ /_________/_________
Email:____________________________________
Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other
Closest Relative or Friend:____ Phone:__________________
Primary Physician:____Phone:__________________
Dentist:____ Phone:__________________

Medical History

Are you under a physician's Care now? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No
Do you or have you taken Phen-Fen or Redux? ☐ Yes ☐ No
Immune Compromised? ☐ Yes ☐ No
Have ever had head/neck injury? ☐ Yes ☐ No
Are you on a special Diet? ☐ Yes ☐ No

Do you have or have you had any of the following? Answer Yes or NO, please ***DO Not*** leave BLank:

AIDS / HIV	☐Yes ☐ No	Depression / Bipolar	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ no
Alcoholism	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No
Allergy /Hay fever	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Eating Disorder	☐ Yes ☐ No	Low BLood Sugar	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy / Seizures	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Nervousness/Anxiety	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Fainting/ Dizziness	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ no
Asthma	☐ Yes ☐ No	Head/ Neck/Back Pain	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐No
Cancer	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Scarlet fever	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cold sore/Fever Blister	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Congenital Heart Defect	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	HPV	☐ Yes ☐ NO	Bacterial Endocarditis	☐ Yes ☐ No

Women Only: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Are You Nursing ? ☐ Yes ☐ No

Please describe any serious illness, injury, hospitalization, or surgeries:

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____

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MEDICATION QUESTIONNAIRE

Please list all medications that you take, including PRESCRIPTION, HERBAL, and OVER THE COUNTER.

Medication	Reason Taking	Office Use Only

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Latex ☐Local Anesthetics ☐Other:

If yes,what kind of reaction? ______________________________

DENTAL QUESTIONNAIRE

Smoke or use smokeless tobacco ☐Yes ☐No
Bite/chew lips or cheeks ☐Yes ☐No
Have dentures that fit poorly ☐Yes ☐No
Have a history of oral cancer ☐Yes ☐No
Have frequent dry mouth ☐Yes ☐No
Clench or grind teeth ☐Yes ☐No
Need to improve nutrient/vitamin intake ☐Yes ☐No
Have a family history of gum disease ☐Yes ☐No
Gums bleed when brushing or flossing ☐Yes ☐No
Have more than 2 alcohol drinks per day ☐Yes ☐No
Use alcohol based mouth rinse ☐Yes ☐No
(Listerine/Scope)
Are you having any oral pain or dental discomfort at this time? ☐Yes ☐No

Brush at least once a day ☐Yes ☐No
Use fluoride toothpaste ☐Yes ☐No
Floss at least once each day ☐Yes ☐No
Drink tap water that has fluoride ☐Yes ☐No
Drink bottled water only ☐Yes ☐No
Have regular dental visits ☐Yes ☐No
Have dental implants ☐Yes ☐No
Have chronic TMJ (jaw) problems ☐Yes ☐No
Have oral piercing(s) ☐Yes ☐No
Are you nervous about having dental treatment? ☐Yes ☐No
Have you had a bad experience in the dental office? ☐Yes ☐No

When you play contact sports, do you use a mouth guard? ☐Yes ☐No ☐Not applicable

When did you last have a dental exam?________________Dental work______________Teeth cleaned______________

What type of toothbrush do you use? Soft______Medium______Hard______

What toothpaste do you use?_____________________ What other hygiene aids do you use?_____________________

What is the main reason for your visit today?____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. *It is my responsibility to inform Northwest Family Dental of any changes in my medical status*. If the patient is under 18 years of age we ask that the parent/guardian stay at the dental office while treatment is rendered. *Parent/guardian must sign for patients under the age of 18.*

Date	Patient/Guardian Signature	FD	RDA	RDH	DDS