Keith and Fisher, D.D.S., PA www.keithfisherdds.com

Preston W. Keith, D.D.S. David M. Fisher, Jr., D.D.S.

YOUR NAME _____ AGE _____ BIRTHDATE _____

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

RESIDENCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ CELL # _____ EMAIL _____

EMPLOYED BY _____ BUSINESS PHONE # _____

PRESENT POSITION _____ YOUR SOCIAL SECURITY NUMBER _____

NAME OF SPOUSE _____ SPOUSE'S SOCIAL SECURITY NUMBER _____

PREFERRED DAYTIME PHONE NUMBER TO CONFIRM YOUR APPOINTMENT _____

WHO IS RESPONSIBLE FOR PAYMENT OF DENTAL SERVICES (If different from above) _____

IN CASE OF EMERGENCY, NAME OF NEAREST FRIEND OR RELATIVE _____ PHONE # _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE _____

HAVE YOU EVER HAD? (Please Circle)

Angina/Chest Pain/Tachycardia/Shortness of breath
Heart Disease/Heart Attack/Heart Surgery
Rheumatic Fever/Heart Murmur
Congenital Heart Lesions/Mitral Valve Prolapse
Arteriosclerosis
Pace Maker
Prosthetic Heart Valves
Abnormal Blood Pressure
Ulcer/Stomach Problems/Intestinal Problems
Tuberculosis/Lung Disease/Emphysema/Asthma
Diabetes/Hypoglycemia/Excessive Thirst
Epilepsy/Seizures/Fainting Spells
Cancer or Tumors
Thyroid Disorders/Endocrine Disorders
Severe Headaches/Migraines
Nervous/Psychiatric Problems
TMJ (Jaw Joint) Disorder/Pain

Sleep Disorders
Kidney/Bladder Trouble
Hepatitis/Liver Disease/Jaundice
Sinus Troubles/Hay Fever/Allergies
Stroke
Glaucoma
Cortisone/ X-Ray Therapy/Chemotherapy
Arthritis/Rheumatism/Gout
Blood Troubles/Anemia/Leukemia/Prolonged Bleeding
Blood Transfusion/Hemophilia
VD (Syphillis, Gonorrhea)
Exposure to AIDS Virus/AIDS
Artificial Devices (knee, hip, etc.)
Use of Tobacco
Drug Dependency/Addiction
Cold Sores/Fever Blisters/Herpes
Sickle Cell Anemia

HAVE YOU EVER EXPERIENCED AN UNUSUAL REACTION OR ALLERGY TO ANY OF THE FOLLOWING? (Please Circle)

Penicillin
Erythromycin
Aspirin
Codeine

Sedatives, Sleeping Pills
Dental Anesthetics, Latex
Other Medications
_____

Have you taken medication for osteoporosis (Actonel, Fosamax, etc.)?

Do you require antibiotic premedication for your dental appointment? ☐ YES ☐ NO

Are you presently taking any medications? ☐ YES ☐ NO Herbal compounds and/or supplements? ☐ YES ☐ NO

Medications presently taking _____ Purpose _____

Women are you pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO Taking birth control pills? ☐ YES ☐ NO

Name of Primary Care Physician _____ Phone # _____

Are you under the care of a physician at this time? ☐ YES ☐ NO If yes who: _____

Date of last physical exam _____ Have you been hospitalized in the last two years? ☐ YES ☐ NO

PATIENT SIGNATURE _____ DATE _____

How may we help you? _____

If you could change anything regarding your smile, what would you change? _____

Are you having any discomfort at this time? _____

Do you have any fears concerning dentistry? _____

	YES	NO
Do you want to save your natural teeth for the rest of your life?	☐	☐
Do you feel you have neglected your teeth?	☐	☐
Are you satisfied with your past dentistry?	☐	☐
Are you self conscious about the appearance of your teeth?	☐	☐
Do your gums ever bleed or hurt at any time?	☐	☐
Are you aware of any swelling or lumps in your mouth or neck?	☐	☐
Have you ever been instructed in homecare procedures in a dental office?	☐	☐

Do you feel your teeth are in good _____ fair _____ poor _____ condition?

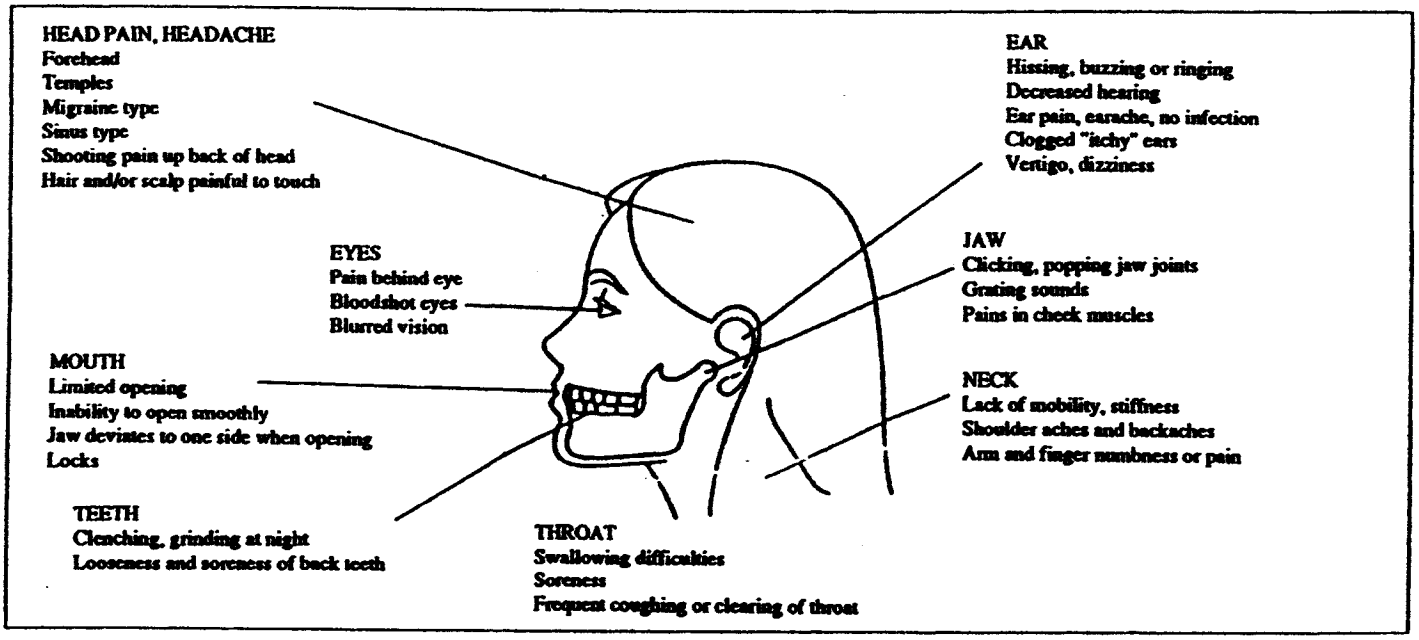
PLEASE CIRCLE ANY ITEM ABOUT WHICH YOU HAVE A QUESTION, INTEREST OR CONCERN.

Difficulty Chewing	Bleeding/Sore gums	Sensitive teeth
Uncomfortable Partial/Full Denture	Crowning or capping teeth	Jaw popping/Soreness
Dental Implants	Mercury in silver fillings	Oral Cancer
Whiter/Brighter teeth	Bridgework	Sealants to prevent decay
Improve appearance of teeth	Dental Implants	Diet & Nutrition
Keeping my natural teeth	NTI- Appliance for migraines/headaches	Itchy stuffy or ringing ears
Health Centered Dentistry	Sleep Apnea/ Sleep appliance	Nitrous Oxide (laughing gas)
Replacing missing tooth/teeth	Bonding teeth	Stale mouth taste or bad breath

Sleeping through your dental treatment

Have you ever worn braces? YES NO Name of Orthodontist _____

Do you have problems: Sleeping on your back? YES NO Getting to sleep? YES NO Staying asleep? YES NO

Do you wake feeling tired? YES NO Do you wake with a headache? YES NO

Please circle on the chart below any of the problems that pertain to you: