ENJOY Dental New Patient Forms

Dental Information

(Please Check All That Apply To You)

Gums bleed when you brush or floss	☐	Earaches, neck pain, or morning headaches	☐
Teeth sensitive to hot, cold, sweets, or chewing	☐	Clicking, popping, or discomfort in jaw joint	☐
Food or floss gets stuck between your teeth	☐	Sores or ulcers in mouth	☐
Currently experiencing dental pain/discomfort	☐	Serious injury to head/mouth	☐
Snore, mouth breathe, or grind teeth at night	☐	Problems with previous dental treatment	☐

Reason for Today's Visit | *Date of Last Dental Exam* | *Date of Last Dental X-Rays*

Medical Information

Family Doctor/Physician Name | *Phone Number*

Have you had a serious illness, operation, or been hospitalized in the last 5 years? **Yes** ☐ **No** ☐

Date of Last Physical Exam:

If yes, what was the illness or problem?

Do you have any known allergies?

Please List:

Please list all medications, supplements, naturals and herbals you are taking:

Review of Systems

I certify that I have no known medical conditions and am negative to all conditions listed above ☐

I certify that I am currently taking no medications, supplements, naturals or herbals ☐

If you have any medical condition or are taking medications, please check all that apply to you in the present or the past

Antibiotic Prophylaxis Needed

- Joint Replacement/Artificial Joints ☐
- Artificial (Prosthetic) Heart Valve ☐
- Congenital Heart Disease (CHD) ☐
- Previously Recommended Antibiotics for Dental Treatment ☐
- Other (explain):

Breathing

- Asthma (Last Hospitalized:) ☐
- Sinus Trouble ☐
- Tuberculosis ☐
- Been told you snore while asleep ☐
- Been told you need a CPAP ☐
- Other (explain):

Other

- Cancer Treatment ☐
- **Other disease/condition?** ☐

Explain:

Muscles, Bones, Immune System

- Osteoarthritis ☐
- Rheumatoid Arthritis ☐
- Osteoporosis ☐
- Hepatitis (A B C D or E) ☐
- STD/HIV/AIDS (Specify:) ☐
- Recurrent/Persistent Infection ☐
- Other (explain):

Brain and Sleep

- Difficulty Sleeping/Sleep Disorders ☐
- Headaches/Migraines ☐
- Difficulty Falling Asleep ☐
- Wake Up During the Night ☐
- Other (explain):

- Chronic Pain ☐
- Cosmetic Surgery ☐

Heart and Blood

- Previous Heart Related Surgery ☐
- High Blood Pressure ☐
- Heart Disease ☐
- Other (explain):

Gut and Hormones

- Diabetes (Current HbA1c:) ☐
- Kidney/Liver Problems ☐
- Heart Burn/Acid Reflux (GERD) ☐
- Eating Disorders: ☐
- Other (explain):

Female Only Are you Pregnant? ☐

If yes, what trimester?

- Head/Neck Injury ☐
- Eye Surgery in Last 6 Months ☐

Name of Patient, Parent, or Guardian | *Signature of Patient, Parent, or Guardian* | *Date*