Christopher J. Cowell, D.M.D.

Family Dentistry

228D East New York Avenue • DeLand, Florida 32724 • Telephone (386) 734-8585

Date_____

PATIENT INFORMATION

Name_____ Birthdate_____ Phone #_____

Address_____ City_____ State_____ Zip_____

Check Appropriate Box ❑ Male ❑ Female ❑ Minor ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Business Address _____ City _____ State_____ Zip_____

Spouse or Parent's Name _____ Employer_____ Work Phone #_____

If Student, Name of School/College _____ City_____ State_____

In case of emergency who should be notified?_____ Phone# _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone #_____

Employer _____ Work Phone #_____

Currently a Patient in our Office: ❑ Yes ❑ No

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # _____

Employer Address _____ City _____ State_____ Zip_____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

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Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

Name _____ Date _____ Birthdate _____

		Yes	No
1	Are you in good health now?	☐	☐
2	Have you ever been hospitalized or had a serious illness?	☐	☐
	If yes, explain _____		
3	Ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	☐	☐
4	Do you use tobacco in any form? If yes, how much _____	☐	☐
5	Are you pregnant or nursing?	☐	☐

GENERAL: CURRENT CONDITIONS

	Yes	No
Tire easily, weakness	☐	☐
Marked weight change	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐
SKIN		
Eruptions (rash) hives	☐	☐
Change in skin color	☐	☐
EYES		
Visual change	☐	☐
Glaucoma	☐	☐
EARS		
Loss of hearing	☐	☐
Ringing in ears	☐	☐
NOSE		
Frequent nosebleeds	☐	☐
Sinus problems	☐	☐
THROAT		
Soreness/hoarseness	☐	☐
NERVOUS SYSTEM		
Stroke	☐	☐
Headaches	☐	☐
Convulsions/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatment	☐	☐
RESPIRATORY		
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/hay fever	☐	☐
Persistent cough	☐	☐
Sputum production (phlegm)	☐	☐
Cough up bloody sputum	☐	☐
Difficulty breathing while lying down	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐
Other _____		

HEART/BLOOD VESSELS

	Yes	No
Rheumatic Fever	☐	☐
Heart murmur	☐	☐
Chest pain/discomfort	☐	☐
Heart attack/trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
Angina	☐	☐
BONE/MUSCLES		
Arthritis/rheumatism	☐	☐
Artificial joints/limbs	☐	☐
DIGESTIVE SYSTEM		
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐
URINARY		
Kidney disease	☐	☐
Increase in frequency of urination (night)	☐	☐
Burning on urination	☐	☐
Bloody urine	☐	☐
Venereal disease	☐	☐
BLOOD		
Hemophilia	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
OTHER		
Radiation therapy	☐	☐
Chemotherapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐
HIV or other immuno-suppressive disorder	☐	☐

(Please complete reverse side)

MEDICAL HISTORY Con't

6 Are you ALLERGIC or have you ever experienced any reaction to the following?

	Yes	No		Yes	No
Local anesthetics (e.g. novocaine)	☐	☐	Codeine	☐	☐
Barbiturates/sedatives/sleeping pills	☐	☐	Aspirin	☐	☐
Penicillin	☐	☐	Sulfa drugs	☐	☐
Other Antibiotics _____			Other _____		

7 Please list all medications & vitamins you are taking & dosage:

_____

_____

_____

_____

_____

_____

8 Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain

_____

9 Physician's Name _____ Phone _____

10 Cardiologist's Name _____ Phone _____

11 Have you ever had any serious trouble associated with previous dental treatment? _____

12 Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

13 Date of your last dental visit _____

14 Have you ever been treated for periodontal disease (gum disease)? _____ When? _____

15 Do you have or have you ever had any of the following?

MOUTH

	Yes	No
Bleeding, sore gums	☐	☐
Unpleasant taste/bad breath	☐	☐
Burning tongue/lips	☐	☐
Frequent blisters, lips/mouth	☐	☐
Swelling/lumps in mouth	☐	☐
Ortho treatments (braces)	☐	☐
Clicking/popping jaw	☐	☐
Difficulty opening or closing jaw	☐	☐

TEETH

	Yes	No
Loose teeth	☐	☐
Sensitive to hot	☐	☐
Sensitive to cold	☐	☐
Sensitive to sweets	☐	☐
Sensitive to biting	☐	☐
Food impaction	☐	☐
Shifting of teeth	☐	☐
Change in bite	☐	☐

ORAL HYGIENE

Do you use the following?

Brush	☐	☐
Dental floss	☐	☐
Fluoride rinse	☐	☐
Other _____		

How often do you brush? _____

Brush is: Soft ☐ Medium ☐ Hard ☐

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient: _____ Date: _____