Print Form

6700 Alexander Bell Dr. Ste 120
Columbia, MD 21046
Tel 410.872.3999
dentistcolumbiamd.com

Joobbani
Dental Designs

Personal Information 1

Patient's Last Name | First Name | Middle Initial

Preferred Name / Nickname | (Responsible Party's Name, if not the patient) | (Relationship to Patient)

Patient Sex: ◯ Male ◯ Female

Date of Birth

Home Address

City | State | ZIP

Mobile Number :

Home Number :

Work Number :

E-mail :

Who may we thank for referring you to our office?
(or please tell us how you heard of us)

Which other family members are patients at this office?

Insurance Information

Subscriber's Name (e.g. name of head of household)

Insurance Company Name

Subscriber's Date of Birth | Subscriber ID Number | Subscriber's Relationship to Patient (e.g., self / spouse)

Name of Subscriber's Employer | Group ID Number

Emergency Contact Information

Name of Emergency Contact | Relationship to Patient

Home Telephone Number | Work Telephone Number | Cell or Other Telephone Number

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Dental History & Treatment Options 2

Date of Last Dental Visit: _____ Former Dentist: _____

Date of Last X-rays: _____ ... in City, State: _____

Yes No Do you feel that your mouth (or jaw) functions properly?

Yes No Are you happy with the appearance of your teeth/smile?

Yes No Are all of your teeth in alignment (straight)?

Would you like to change anything about your teeth/smile?

Yes No Do you have any old fillings, crowns, or dental treatment(s) that you are concerned about or unhappy with?

Please let us know if you would like information about any of the following:

☐ Invisalign (clear braces) ☐ Porcelain veneers ☐ Whitening / Bleaching ☐ Making teeth look taller ☐ Closing gaps between teeth

Yes No Are you fearful of dental treatments?

If YES, rate your fear level from 1 (some fear) to 10 (incredibly fearful) _____

What is the trigger for your fear? (check all that apply)

☐ Needles ☐ Smells ☐ Sounds ☐ Fear of pain

Check if you have had problems with any of the following:

☐ Bad breath	☐ Food collection between teeth	☐ Periodontal (gum) treatment
☐ Bleeding gums	☐ Grinding/clenching teeth	☐ Prolonged bleeding after extraction
☐ Clicking or popping jaw	☐ Headaches	☐ Sensitivity to biting/chewing
☐ Difficult opening or closing of jaw	☐ Jaw pain or tiredness	☐ Sensitivity to cold/hot/sweets
☐ Difficult extractions in the past	☐ Loose teeth or broken fillings	☐ Sores, lumps, growths in your mouth
☐ Dry mouth	☐ Orthodontic treatment	☐ Swollen or tender gums

Medical History

Date of Last Physician Visit: _____ Name of Physician: _____

... in City, State: _____ Tel. No.: _____

Yes No Have you had any serious illnesses, operations, or hospitalizations? If YES, please give dates and reason: _____

Yes No Have you ever had a blood transfusion? If YES, please give dates and reason: _____

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Medical History (continued) 3

Check any of the following which apply to you:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis -or- Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial / Replacement Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical / Drug Addiction
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough -- Persistent or Bloody
- ☐ Diabetes -- Type (1 or 2): _____
- ☐ Emphysema
- ☐ Epilepsy / Seizures
- ☐ Fainting / Dizziness
- ☐ Frequently Tired
- ☐ Glaucoma
- ☐ Hay Fever / Seasonal Allergies
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmurs / Irregular Beat
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis - Type: _____
- ☐ Herpes / Cold Sores (blisters)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash / Hives
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Women only:

◯ Yes ◯ No Are you currently pregnant? (or think that you might be?)

◯ Yes ◯ No Are you nursing?

Tobacco user?

◯ Yes ◯ No

What kind, how many years, how often?

Medications you are currently taking: (including over-the-counter)

_____ _____

_____ _____

_____ _____

Are you currently taking or have you taken any of the following?

- ☐ Fen-Phen/Redux
- ☐ Actonel
- ☐ Boniva
- ☐ Fosomax

Vitamins / Minerals / Supplements / Herbal:

_____

_____

Allergies:

- ☐ Aspirin
- ☐ Barbiturates (e.g. sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic (e.g. Novocaine)
- ☐ Antibiotics (e.g. Penicillin)
- ☐ Sulfa
- ☐ Others: _____

_____
Signed By

Current Date _____