WELCOME

Thank you for trusting us with your oral health care. We promise to provide you with the finest care available. If you have any questions, please do not hesitate to ask.
–Dr. Robert C. Rawdin, DDS

Date_____
Social Security
Number_____
Patient Name_____
Address_____
City_____
State_____Zip_____
Email_____
Sex__M_F_ Age_____
Birthdate_____
_Married _Widowed _Single _Minor
_Separated _Divorced _Partnered
Occupation_____
Patient Employer_____
Employer Address_____
Employer Phone_____
Spouse's Name_____
Birthdate_____
SS#_____
Spouse's Employer_____

Whom may we thank for referring you?_____

PHONE NUMBERS

HOME (_____)_____ WORK (____)_____ CELL (____)_____
SPOUSE'S WORK_____
BEST TIME TO REACH YOU_____

IN CASE OF EMERGENCY, CONTACT (Someone who does not live in your household)

NAME_____ RELATIONSHIP_____
HOME PHONE(___)_____ WORK PHONE (___)_____

DENTAL HISTORY

Reason for today's visit_____
Former dentist_____
City/State_____
Date of last dental visit_____
Date of last dental x-rays_____
Place a mark on "yes"or "no" to indicate if you have any of the following:
Bad breath __Y __N Bleeding gums Y__ N__ Blisters on lips or mouth Y__ N__
Burning sensation on tongue Y__ N__ Chew on one side of mouth Y__ N__
Cigarette smoking Y__ N__ Clicking or popping jaw Y__ N__ Dry Mouth Y__ N__
Fingernail biting Y__ N__ Food collection between teeth Y__ N__ Grinding teeth Y__ N__
Gums swollen or tender Y__ N__ Jaw pain or tiredness Y__ N__ Lip or cheek biting Y__ N__
Loose teeth or broken fillings Y__ N__ Mouth breathing Y__ N__ Mouth pain, brushing Y__ N__
Orthodontic treatment Y__ N__ Pain around ear Y__ N__ Periodontal treatment Y__ N__

Sensitivity to cold Y__ N__ Sensitivity to sweets Y__ N__ Sensitivity when biting Y__ N__
Sores or growths in mouth Y__ N__ How often do you floss?_____
How often do you brush? _____

MEDICAL HISTORY

Physician's Name_____
Date of last visit_____
Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phenteremine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Y__ N__

Place a mark on "yes'" or "no" to indicate if you have had any of the following:
AIDS/HIV_____Y__N__ Epilepsy_____Y__N__ Respiratory Disease Y__N__
Anemia_____ Y__N__ Fainting or dizziness Y__N__ Rheumatic Fever Y__N__
Arthritis_____ Y__N__ Glaucoma___ Y__N__ Scarlet Fever_____Y__N__
Artificial Heart Valves_____Y__N__ Headaches_____ Y__N__
Artificial Joints_____ Y__N__ Heart Murmur___ Y__N__
Asthma_____Y__N__ Heart Problems__Y__N__ Shortness of breath_Y__N__
Back Problems_Y__N Hepatitis Type___Y__N__ Sinus Trouble ____Y__N__
Bleeding abnormally with extractions or surgery_____Y__N__
Blood Disease__Y__N__ Herpes_____Y__N__ Skin Rash_____Y__N__
Chemical Dependency_____Y__N__ High Blood Pressure __Y__N__
Jaundice_____Y__N__ Special Diet___Y__N__ Jaw Pain_____Y__N__
Chemotherapy Y__N__ Kidney Disease Y__N__ Stroke_____Y__N__
Circulatory Problems_____Y__N__ Liver Disease_____Y__N__
Congenital Heart Lesions____Y__N__ Low Blood Pressure_____Y__N__
Cortisone Treatments_____Y__N__ Swollen feet or ankles_____Y__N__
Cough, persistent or bloody__Y__N__ Mitral Valve Prolapse_____Y__N__
Diabetes_____Y__N__ Nervous problems Y__N__ Thyroid Problems Y__N__
Emphysema___Y__N__ Pacemaker_____Y__N__ Tonsillitis_____Y__N__
Psychiatric Care Y__N__ Tuberculosis____Y__N__ Tumors_____Y__N__
Radiation Treatment_____Y__N__ Venereal Disease_____Y__N__
Ulcer_____Y__N__ Weight Loss, unexplained_____Y__N__
Do you wear contact lenses?_____Y__N__
WOMEN: Are you Pregnant?_____Y__N__ Nursing?_____Y__N__
Taking Birth Control Pills? Y__N

MEDICATIONS

Please list all medications you are currently taking:

_____
_____
_____
_____

ALLERGIES

Aspirin __ Local Anesthetic __
Barbiturates __ Penicillin __
Codeine __ Sulfa __
Iodine __ Latex__
Other _____
_____

PATIENT SIGNATURE_____