COASTAL
Dental Arts

NEW PATIENT QUESTIONNAIRE

Name:	**Date of Birth:**
Address:	**Phone #:** **Home:** **Cell:** **Work:**
Email:	**Emergency Contact** **Name/relationship:** **Phone number:**
Primary Care Physician/Phone number:	
Preferred Pharmacy Name, City, and Street Address:	

General Medical History: (Please circle all that apply or NONE)

NONE
Anxiety
Autoimmune disease
Anemia
Asthma
Diabetes
Epilepsy/seizure/fainting
Heart attack
High blood pressure
Gastrointestinal disease
Kidney problems
Neurological condition
Osteoporosis
Cancer/chemotherapy/radiation treatment
(Reason: _____)
Severe headaches
Stroke

OTHER:_____

Dental History (Please circle all that apply or NONE)

NONE
Dental pain
Sensitivity (hot, cold, sweets, pressure)
Brux/grind teeth
Dry mouth
Bleeding gums
Sores/ulcers in mouth
Ear aches or neck pain
Gum recession

Last dental exam (month/year): _____/_____
Last dental x-rays (month/year): _____/_____
Have you had periodontal treatment? □ No □ Yes
Have you had orthodontic treatment? □ No □ Yes
Have you had previous injury to head or mouth? □ No □ Yes
How do you feel and would you change anything about your smile?

Medications (List medications or circle NONE)

NONE
Please list all of your current medications:

Allergies (List allergies or circle NONE)
NONE Please list all of your medication allergies:

Social History
What is/was your occupation? _____ Are you retired? □ No □ Yes What name would you like to be called? _____

Review of Systems / Alerts		
Do you have osteoporosis (weak bones)?	□ No	□ Yes _____
Do you take any medications for osteoporosis?	□ No	□ Yes _____
Do you have bone pain or multiple myeloma?	□ No	□ Yes _____
Do you have metastatic cancer or Paget's disease	□ No	□ Yes _____
Have you had bad reaction to lidocaine?	□ No	□ Yes _____
Have you had bad reaction to epinephrine?	□ No	□ Yes _____
Do you have a pacemaker?	□ No	□ Yes _____
Do you have a defibrillator?	□ No	□ Yes _____
Do you have an artificial heart valve?	□ No	□ Yes _____
Do you take blood thinners?	□ No	□ Yes _____
Do you have problems with bleeding?	□ No	□ Yes _____
Have you ever been infected with hepatitis B or C?	□ No	□ Yes _____
Do you have HIV?	□ No	□ Yes _____
Have you had artificial joints (hip, knee)?	□ No	□ Yes _____
Do you require premedication prior to procedures?	□ No	□ Yes _____
Are you pregnant, planning a pregnancy, or breastfeeding?	□ No	□ Yes _____
Do you use tobacco?	□ No	□ Yes _____

Coastal Dental Arts offers the option of a free consultation to answer questions you may have about improving or maintaining your smile with veneers, replacing missing teeth with dental implants or discussing sleep apnea dental appliance for obstructive sleep disorder.

What would you like to discuss with the doctor at your consultation visit?

With my signature below, I submit that the above information is accurate to the best of my knowledge. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____

Patient (or Guardian) Signature Date