Littleton Dental
7735 W Long Dr, # 9
Littleton, CO 80123
Ph # : 303-933-8880
Fax # : 303-932-6847

Patient Personal Information

Title		Nickname		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				Student		SSN	
Email				School Name			
				Referral Type			

Person responsible/guarantor for paying bills

Title		Nickname		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				SSN			
Email							

Do you have Primary Dental Insurance? __ Yes __ No				Do you have Secondary Dental Insurance? __ Yes __ No			
Group No/Name				Group No/Name			
Insurance Name				Insurance Name			
Phone #				Phone #			
Employer Name				Employer Name			
Subscriber Last, First				Subscriber Last, First			
Subscriber Address				Subscriber Address			
City, State, Zip				City, State, Zip			
Relationship to Patient		Birth Date		Relationship to Patient		Birth Date	
Subscriber ID				Subscriber ID			

Patient Medical Information

- ☐ Y ☐ N No Known Allergies

ALLERGIC TO

- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Oral Bisphosphonate
- ☐ Y ☐ N No Epinephrine
- ☐ Y ☐ N Tetracycline
- ☐ Y ☐ N latex
- ☐ Y ☐ N Prescription Topical
- ☐ Y ☐ N Percocet
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Vicodin
- ☐ Y ☐ N other allergies

Check, if applicable

- ☐ Y ☐ N No Change Since Last Recorded
- ☐ Y ☐ N No Known Concerns or Issues
- ☐ Y ☐ N STENTS
- ☐ Y ☐ N AIDS/HIV Infection
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Anorexia / Bulimia
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma / Hay Fever
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Blood Thinners
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Circulatory problems
- ☐ Y ☐ N Damaged Heart Valve
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Fainting Spells / Seizures
- ☐ Y ☐ N Fibromyalgia
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Heart Attack / Stroke
- ☐ Y ☐ N Heart Disease / Angina
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis / Jaundice
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney / Bladder Trouble
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Low Blood Pressure
- ☐ Y ☐ N Mental Health Problems
- ☐ Y ☐ N Nervous System /Problems
- ☐ Y ☐ N OSTEOPROSIS
- ☐ Y ☐ N Pacemaker
- ☐ Y ☐ N PREGNANT
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Scarlet Fever
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Thyroid Problems

Other

- ☐ Y ☐ N See Dental Questionnaire
- ☐ Y ☐ N See Medical Questionnaire
- ☐ Y ☐ N See Scanned Documents: Pt Note

Dental Questionnaire

Dental Questionnaire

Name of previous Dentist

Phone

Date of your last cleaning

Last exam date

Do your gums bleed while brushing or flossing ?

Are your teeth sensitive to hot, cold or sweets ?

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ?

Have you ever had burning of the tongue or cracking of the corners of your mouth ?

Have you had any head, neck or jaw injuries ?

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ?

Do you clench or grind your teeth ?

Have you ever had orthodontic treatment ?

Are you happy with your smile ?

Do you have an unpleasant taste or odor in your teeth/mouth ?

Do you want to learn to control your dental disease and retain your teeth ? ☐

Additional Comments

Medical Questionnaire

Medical Questionnaire

Family Physician

Phone

Are you currently under care of a Physician ?

If Yes, what is the condition being treated ?

Have you had any serious illness, operation or been hospitalized within the past 5 years ?

If Yes, what illness or problem ?

Are you currently taking any medication ?

If Yes, what ?

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)

Have you ever taken the diet control drug Fen-Phen ?

Do you use alcoholic beverages ?

Do you smoke ?

Women Only

Are you pregnant?

If Yes, what is your due date ?

Are you currently nursing ?

Are you on hormone replacement therapy ?	
Additional Comments	
Any Disease, Condition or Problem not Listed ? Please list	
Senior Citizen	
Are you in a wheelchair?	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**