MARK TICKLE DMD
Family & Implant Dentistry

Patient Name:

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

Your Primary Care Physician's name, address, and phone number:

What is the date (or approximate date) of your last medical exam?

◯ Are you currently under the care of a physician due to specific condition?

◯ Have you been hospitalized within the last 5 years due to a surgery or illness?

◯ Do you have any conditions, diseases, etc., that we should be aware of?

If any of the previous questions are marked please explain:

When was your last visit the dentist? And prior Dentist name, and location:

What is the reason for your dental visit today?

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2-6 weekly ◯ 1-6 monthly ◯ Seldom ◯ Never

If you could change anything about your mouth, teeth, or smile, what would it be?

Please mark any of the following to indicate Yes in response to the question:

◯ Do your gums bleed when you brush or floss?

◯ Do your teeth experience sensitivity to cold or hot temperatures?

◯ Are any of your teeth currently causing you pain?

◯ Do you grind your teeth (either consciously or during sleep)?

◯ Are any of your teeth loose, or are you concerned about any teeth loosening?

◯ Do you currently have any dental implants, dentures, or partials?

◯ Have you ever had complications following dental treatment?

◯ Do you currently use or have in the past used tobacco (smoking or chewing)?

◯ Do you chew gum or ice?

Are you currently or have you taken in the past any of the listed Osteoporosis Drugs?

◯ Fosamax ◯ Zometa ◯ Didronel ◯ Reclast ◯ Boniva ◯ Actonel ◯ Aclasta

◯ Aredia ◯ Atelvia ◯ Skelid ◯ Prolia ◯ Xgeva

Are you currently or have you taken in the past any of the listed Chemotherapy Drugs?

◯ Sutent ◯ Nexavar ◯ Avastin ◯ Rapmune

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Please indicate if you have experienced any of the following:

- [ ] Allergies
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Aspirin Allergy
- [ ] Asthma
- [ ] Back Problems
- [ ] Birth Control Meds
- [ ] Bleeding Abnormally
- [ ] Blood Disease
- [ ] Blood Thinner
- [ ] Cancer
- [ ] Chemical Dependency
- [ ] Chemotherapy
- [ ] Circulatory Problems
- [ ] Codeine Allergy
- [ ] Cough, Persistant
- [ ] Diabetes
- [ ] Dizziness
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Epiniphrine RXN
- [ ] Fainting
- [ ] Free Bleeder
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Headaches
- [ ] Heart Attack
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart problems
- [ ] Hepatitis
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Iodine Allergy
- [ ] Jaundice
- [ ] Jaw Pain
- [ ] Kidney Disease
- [ ] Latex Allergy
- [ ] Low Blood Pressure
- [ ] Lupus
- [ ] MS
- [ ] MVP
- [ ] Nervous Disorders
- [ ] Osteoporosis
- [ ] Other
- [ ] Pacemaker
- [ ] Penicillin Allergy
- [ ] Pre-Medicate
- [ ] Psychiatric Care
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Seizures
- [ ] Sinus Problems
- [ ] STD
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Sulfa Allergy
- [ ] Thyroid Problems
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Weight Loss,Unexplai

- [ ] Chronic Fatigue Syndrome
- [ ] Fibromyalgia
- [ ] Dry Mouth

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- [ ] Dialysis
- [ ] Cerebral Palsy
- [ ] Acid Reflux
- [ ] Sleep Apnea
- [ ] Snoring
- [ ] Fever Blisters
- [ ] Mental Disability
- [ ] Physical Disability
- [ ] Sensitivity to Light

Allergies-Please check appropriate box below

- [ ] No Known Allergies
- [ ] Aspirin
- [ ] Barbiturates (Sleeping pills)
- [ ] Codeine
- [ ] Iodine
- [ ] Latex
- [ ] Local Anesthetic
- [ ] Penicillin
- [ ] Sulfa
- [ ] Other
- [ ] Erythromycin
- [ ] Lortab
- [ ] Vicodin
- [ ] Dye

Please list all current medications

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

WOMEN ONLY: Are you nursing?

◯ Yes ◯ No

If Yes, when is the due date?

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Signature of patient, parent, or guardian:

Signature: _____ Date:

Response Date:

Patient Information

Please take a few minutes to help us get to know you, or to update your information. This helps us to ensure the quality of your care is excellent!

Chart #. _____
FOR OFFICE USE ONLY

Patient Name:* _____ * _____ _____ _____
Last First MI Preferred Name

Title: _____ Gender:* ◯ Male ◯ Female Family Status:* ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ Prev. Visit: _____ Email Address: _____

Phone:* _____ _____ _____ _____ Best time to call: _____
Home Work Ext Mobile

Address:* _____ _____

* _____ * _____ * _____
City State Zip Code

Patient's Employer/School Name and Occupation

_____

Employer/School Phone

_____

Emergency Contact: (Please provide name and number of contact in the space below)

* _____

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Spouse or Responsible Party Information

The following is for: * ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: * Last * First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: * ◯ Male ◯ Female Family Status: * ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: * Email Address:

Phone: * Home Work Ext Mobile Best time to call:

Address: *

* City * State * Zip Code

Primary Dental Insurance Information

Name of Insured (Last, First, MI) Insured's Birthdate

Insurance Plan Name:

ID# Group#

Insured's Employer Name: