Dr. Aurina Poh-Matacio, DDS, Inc.

Patient Information Form

Today's Date______________________

Patient Name: First_________________ MI ____ Last __________________ Nickname______________________________

Address: Street ___________________ City ___________________________State _____ Zip_________________________

Phone: Home ____________________ Work __________________________ Cell __________________________________

E-mail address: ____

By providing your e-mail address you agree to receive (check one or both) ☐ Appointment Reminders ☐ Estimates

Social Security Number________________________________ **Date of Birth**_______________________________________

Drivers License # _____________________________________ **State** ____

Patient Employed By _______________ **Occupation** ____________________ **Phone** _______________________________

Address: Street___________________ City ___________________________ State _____ Zip _________________________

Sex ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified? ____

Relationship to Patient _______________ **Home Phone** ____________________ **Mobile Phone** ____________________

Is the patient a Minor? ☐ Yes ☐ No **Full-time Student** ☐ Yes ☐ No **Name of school**__________________

Name of Responsible Party: First _____________________________ Last ____

Date of Birth _____________ **Relationship to Patient** ☐ Self ☐ Spouse ☐ Parent ☐ Other________________

If patient is a minor, primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Address: (if different from patient) Street___________________ City _______________ State ___________ Zip___________

Phone: Home ___________________ Work __________________________ Cell __________________________________

Employer (if different from above)______________________ **Occupation** _______________ **Phone** ____________________

Address: Street ___________________ City ______________________ State ________ Zip ____________________________

Whom may we thank for referring you?

☐ One of our valued patients (name of patient) ____

☐ Advertisement ___________________________ ☐ Local Dental Society ____

☐ Our Web site ☐ Other ____

Please list other members of your immediate family who are patients in our practice _______________________________

Dr. Aurina Poh-Matacio, DDS, Inc.

Dental Health History Form

Today's Date ____________

Patient Name: First __________________________ **MI** ____ **Last** _________________________ **Nickname** ________________

What are your goals in coming to our practice today? ____

Date of last radiographs (x-rays) and exam ____________________________

Date of last hygiene continuing care appointment (cleaning or periodontal maintenance) ______________________________

Former Dentist ____ **Phone** ____________________

Address: Street ______________________________ City _______________________ State _____ Zip ____________________

Have you had problems with prior dental treatment? ____

Are you experiencing any pain now? ☐Yes☐ No If yes, why? ____

Have you ever been pre-medicated for dental treatment?☐Yes☐ No If yes, why? ___________________________________

What concerns do you currently have with your oral health or smile?

Jaw joint pain
Clenching or grinding of teeth
Discolored teeth
Crowding/Crooked teeth
Missing teeth
Spaces in between teeth
Loose tooth/teeth
Tooth shape or size

Unhappy with appearance to teeth
Overbite
Underbite
Uncomfortabel bite
Old fillings (gold or silver)
Old crowns
Speech problems
Too much gum tissue when I smile

Tooth sensitivity to hot/cold or anything
Food gets caught in between teeth
If yes, where? _____________________
Difficulty Chewing
If yes, where? _____________________
Bad breath
Other

Have your ever had orthodontic treatment?☐ Yes☐ No Please describe ____

Have you ever had periodontal (gum tissue) **treatment, such as deep cleanings, root planning, periodontal surgery** ☐Yes☐ No

Have you whitened your teeth in the past?☐Yes☐ No **Are you interested in learning more about the following?**

Teeth Whitening
Orthodontic treatment
Veneers

Tooth-colored fillings
Dental implants
How to prevent periodontal disease

At-home oral hygiene care
Periodontal treatment during pregnancy
Oral hygiene care

Has there been a change in your health within the last year? ____

Have you gone to the hospital or emergency room or had a serious illness in the last three years? _______________________

Are you being treated by a physician now? Please describe ____

Are you allergic to or have you had a reaction to any of the following? (please circle Yes or No for each)

Yes / No Aspirin
Yes / No Codeine
Yes / No Latex
Yes / No Local anesthetic (Novocain, Zylocaine or Epinephrine)

Yes / No Valium
Yes / No Penicillin
Yes / No Any Food Items
Yes / No Erythromycin

Yes / No Tetracycline
Yes / No Vicodin
Yes / No Nitrous oxide
Yes / No Metal

Please circle any of the following you have or have had in the past:

AIDS	Cancer	Heart disease	Kidney Problems	Rheumatic Fever
Alcoholism	Cold Sores	Heart Murmur	Leukemia	Rheumatism
Alzheimer's	Diabetes	Heart Pacemaker	Low Blood Pressure	Scarlet Fever
Anemia	Drug Addiction	Heart Surgery	Liver Disease	Stroke
Angina/Chest Pain	Emphysema	Hemophilia	Mitral Valve Prolapse	Thyroid Disease
Artificial Heart Valve	Epilepsy or Seizures	Herpes	Pain in Jaw	Tuberculosis
Artificial Joint	Fainting or Dizziness	Hives or Rash	Parathyroid Disease	Tumors/Growths
Arthritis/Gout	Fever Blisters	HIV Positive	Radiation/Chemotherapy	X-Ray Treatment
Asthma	Glaucoma	High Blood Pressure	Recent Transfusion	Yellow Jaundice
Bleeding/Bruise Easily	Heart Attack/Failure	Hypoglycemia	Renal Dialysis	

Are you taking or have you taken any of the following in the last three months? (Please circle Yes or No for each)

Yes / No Recreational drugs	Yes / No Tobacco in any form	Yes / No Antibiotics
Yes / No Over-the-counter medicines	Yes / No Alcohol	Yes / No Supplements
Yes / No Weight loss medications	Yes / No Bisphosphonate (Fosamax)	Yes / No Aspirin
Yes / No Cortico-Steroids		

Please list all medication you are currently taking ____

Women only (Please circle Yes or No for each)

Yes / No **Are you or could you be pregnant? If Yes, what month**?____

Yes / No **Are you nursing?** Yes / No **Are you taking birth control pills?**

All patients (Please circle Yes or No for each)

Yes / No **Do you have or have you had any other diseases or medical problems NOT listed on this form?**

If Yes, explain ____

Yes / No **Have you ever taken Fen-Phen? If yes, when** ____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

Patient Signature (Parent or Guardian) X ____Date _______BP ___________

Reviewed by Doctor _____________________________________ ____________Date___________________________________

MEDICAL UPDATES I have read my MEDICAL HISTORY and confirm that it adequately states past and present conditions.

Date	**Changes**		**Patient's Signature**	**BP**	**Reviewed by**
____________	______________________________	☐ None	____________________	__________	________________
____________	______________________________	☐ None	____________________	__________	________________
____________	______________________________	☐ None	____________________	__________	________________