Keith and Fisher, D.D.S., PA www.keithfisherdds.com

Preston W. Keith, D.D.S. David M. Fisher, Jr., D.D.S.

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ______________________ AGE ____ BIRTHDATE ____________

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

RESIDENCE ADDRESS ______________________ CITY ________ STATE ______ ZIP ________

HOME PHONE # ______________ CELL # ______________ EMAIL ______________

EMPLOYED BY ______________________ BUSINESS PHONE # ______________

PRESENT POSITION ______________ YOUR SOCIAL SECURITY NUMBER ______________

NAME OF SPOUSE ______________ SPOUSE'S SOCIAL SECURITY NUMBER ______________

NUMBER WE CAN CALL IN DAYTIME TO CONFIRM YOUR APPOINTMENT ______________

WHO IS RESPONSIBLE FOR PAYMENT OF DENTAL SERVICES (If different from above) ______________

IN CASE OF EMERGENCY, NAME OF NEAREST FRIEND OR RELATIVE ______________ PHONE # ________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE ______________

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: Drs. Name:

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No

List Medications:

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ______________

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ______________

Comments: Would you like appointments confirmed via email or text?

PATIENT SIGNATURE ______________________ DATE ______________

How may we help you? ____________________

If you could change anything regarding your smile, what would you change? ____________________

Are you having any discomfort at this time? ____________________

Do you have any fears concerning dentistry? ____________________

	YES	NO
Do you want to save your natural teeth for the rest of your life?	☐	☐
Do you feel you have neglected your teeth?	☐	☐
Are you satisfied with your past dentistry?	☐	☐
Are you self conscious about the appearance of your teeth?	☐	☐
Do your gums ever bleed or hurt at any time?	☐	☐
Are you aware of any swelling or lumps in your mouth or neck?	☐	☐
Have you ever been instructed in homecare procedures in a dental office?	☐	☐

Do you feel your teeth are in good ________ fair ________ poor ________ condition?

PLEASE CIRCLE ANY ITEM ABOUT WHICH YOU HAVE A QUESTION, INTEREST OR CONCERN.

Difficulty Chewing	Bleeding/Sore gums	Sensitive teeth
Uncomfortable Partial/Full Denture	Crowning or capping teeth	Jaw popping/Soreness
Dental Implants	Mercury in silver fillings	Oral Cancer
Whiter/Brighter teeth	Bridgework	Sealants to prevent decay
Improve appearance of teeth	Dental Implants	Diet & Nutrition
Keeping my natural teeth	NTI- Appliance for migraines/headaches	Itchy stuffy or ringing ears
Health Centered Dentistry	Sleep Apnea/ Sleep appliance	Nitrous Oxide (laughing gas)
Replacing missing tooth/teeth	Bonding teeth	Stale mouth taste or bad breath

Sleeping through your dental treatment

Have you ever worn braces? YES NO Name of Orthodontist ____________________

Do you have problems: Sleeping on your back? YES NO Getting to sleep? YES NO Staying asleep? YES NO

Do you wake feeling tired? YES NO Do you wake with a headache? YES NO

Please circle on the chart below any of the problems that pertain to you:

HEAD PAIN, HEADACHE
Forehead
Temples
Migraine type
Sinus type
Shooting pain up back of head
Hair and/or scalp painful to touch

EAR
Hissing, buzzing or ringing
Decreased hearing
Ear pain, earache, no infection
Clogged "itchy" ears
Vertigo, dizziness

EYES
Pain behind eye
Bloodshot eyes
Blurred vision

JAW
Clicking, popping jaw joints
Grating sounds
Pains in cheek muscles

MOUTH
Limited opening
Inability to open smoothly
Jaw deviates to one side when opening
Locks

NECK
Lack of mobility, stiffness
Shoulder aches and backaches
Arm and finger numbness or pain

TEETH
Clenching, grinding at night
Looseness and soreness of back teeth

THROAT
Swallowing difficulties
Soreness
Frequent coughing or clearing of throat