D. Greg Seal

PROSTHODONTICS

D. GREG SEAL, DDS, PC
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PLEASE COMPLETE BOTH SIDES OF THIS FORM

CONFIDENTIAL PATIENT INFORMATION

Name: ❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms.

____
Last First MI

Preferred Name: ______________________________

Date: ______________________________

❑ Male ❑ Female ❑ Married ❑ Single ❑ Child ❑ Other

Social Security #: ______________________________

Birth Date: ______________________________

Home Phone: (________) ______________________

Work Phone: (________) ______________________

Cell Phone/Other: (________) ______________________

Please circle preferred contact # HOME WORK CELL

E-mail address: ______________________________

Address:

____
Street Apt/Unit Number

____
City State Zip

Occupation: ______________________________

Employer Name: ______________________________

Address:

____
Street Apt/Unit Number

____
City State Zip

In Case of Emergency please contact:

____
Name

(________) ______________________________
Phone

Referred by: ______________________________

Have you ever had any of the following? Please check all that apply.

❑ Allergies (to) ______________
____
❑ Anemia
❑ Anxiety
❑ Arthritis
❑ Artificial Joints
❑ Asthma
❑ Blood Disease
❑ Cancer
❑ Diabetes
❑ Dizziness
❑ Epilepsy
❑ Excessive Bleeding
❑ Fainting
❑ Glaucoma
❑ Hay Fever
❑ Head Injuries
❑ Heart Disease
❑ Heart Murmur
❑ Hepatitis
❑ High Blood Pressure
❑ HIV Positive
❑ Jaundice
❑ Kidney Disease
❑ Liver Disease
❑ Mental Disease
❑ Metal Allergies
❑ Mitral Valve Prolapse
❑ Pacemaker/Defibrillator
❑ Radiation Treatment
❑ Respiratory Problems
❑ Rheumatic Fever
❑ Seizures
❑ Sexually Transmitted Disease
❑ Sinus Problems
❑ Smoker/Tobacco Use
❑ Stomach Problems
❑ Stroke
❑ Tuberculosis
❑ Tumors
❑ Ulcers
❑ Other (Please list)
____
____

Personal Physician: ______________________________

Phone: (________) ______________________________

City: ______________________________

Do you need a referral to a physician or other medical specialist? (i.e.: Internist, ENT, Dermatologist, Plastic Surgeon) ❑ Yes ❑ No

Have you been hospitalized in the last 5 years? ❑ Yes ❑ No

Reason: ______________________________

Are you currently being treated by a physician? ❑ Yes ❑ No

Reason: ______________________________

Have you had a joint replacement surgery? ❑ Yes ❑ No

Have you taken an oral or I.V. bisphosphonate drug? (i.e. Fosamax, Actonel, Boniva, Reclast, etc.) ❑ Yes ❑ No

Are you currently taking any medications or drugs? ❑ Yes ❑ No

For what disease? ______________________________

Please list: ______________________________
____

Are you allergic to any medications? ❑ Yes ❑ No

Please list: ______________________________

Are you Pregnant? ❑ Yes ❑ No Due Date: ______________

If the patient is a minor or another party is responsible for the patient, please provide the following:

Name: ______________________________

Social Security #: ______________________________

Birth Date: ______________________________

Preferred Contact Phone: (________) ______________________________

DENTAL HISTORY

Reason for today's visit: ______________________________

____

____

____

____

____

Date of last dental visit: ______________________________

When did you last have dental x-rays taken? ______________________________

Where? ______________________________

Have you had orthodontic treatment? ❏ Yes ❏ No

Have you had periodontal (gum) treatment? ❏ Yes ❏ No

Have you had any dental implants placed? ❏ Yes ❏ No

Please check all of the statements that apply:

I am concerned about:

❏ the appearance of my teeth or smile.
❏ the color of my teeth.
❏ the position or angle of one or more of my teeth.
❏ the shape of one or more of my teeth.

I sometimes have:

❏ sensitivity to cold foods or beverages.
❏ sensitivity to hot foods or beverages.
❏ clicking or pain in my jaw.
❏ sore spots in my mouth.
❏ bleeding in my gums.
❏ bad breath.
❏ pain when biting or chewing.
❏ headaches or neck and shoulder pain.

Do you wear dentures? ❏ Yes ❏ No

How many? ______________________________

How long have you worn dentures? ______________________________

How long have you worn your present dentures? ______________________________

If you are currently having a denture problem, is it related to:

❏ Pain ❏ Discomfort ❏ Appearance ❏ Function

Do you now, or have you ever, had pain in your jaw joint or the sides of your face (in or around the ears)?
❏ Yes ❏ No

Do you have a clicking jaw joint or have you ever experienced an inability to move your jaw or open your mouth widely?
❏ Yes ❏ No

Have you had any trouble associated with any previous dental treatment? ❏ Yes ❏ No

To the best of my knowledge, all preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

____
Signature of patient, parent or guardian

____
Date

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