New Patient Information

Quincy Tan, DDS & Maggie Thai, DDS

Have you ever had:

Periodontal disease/gum treatment	☐ Yes	☐ No	Discomfort in your jaw joint (TMJ/TMD)	☐ Yes	☐ No
Orthodontics treatment	☐ Yes	☐ No	Your teeth ground or bite adjusted	☐ Yes	☐ No
Oral surgery	☐ Yes	☐ No	Serious injury to the mouth or head	☐ Yes	☐ No
A bite plate or mouth guard	☐ Yes	☐ No			

If yes to any of the previous questions, please describe _____

_____

Is there anything else about your past dental treatment(s) that you would like us to know? _____

_____

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No

If yes, for what? _____

Hospital or Physician's name _____ Phone _____

Hospital or Physician's City _____ State _____

Have you taken any medications or drugs in the past two years? ☐ Yes ☐ No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines) ☐ Yes ☐ No

If yes, please explain _____

Have you ever taken Fen-Phen? ☐ Yes ☐ No

If so, how long ago? _____

Have you been to the doctor to check for heart problems? ☐ Yes ☐ No

If so, what are the problems? _____

Do you use tobacco? ☐ Yes ☐ No **Do you use alcohol or any other controlled substance?** ☐ Yes ☐ No

Women only:

Are you pregnant or think you may be pregnant?	☐ Yes	☐ No	Are you nursing?	☐ Yes	☐ No
Are you taking birth control pills?	☐ Yes	☐ No			

Indicate which of the following you have had or have at present:

AIDS/HIV	☐ Yes	☐ No	Difficulty Breathing	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Alcohol/Drug Abuse	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Allergies or Hives	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Nervousness/Anxiety	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Psychiatric/		
Artificial Heart Valve	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Psychological Care	☐ Yes	☐ No
Artificial Bones/Joints	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart (Surgery, Disease,			Rheumatic/Scarlet Fever	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Attack)	☐ Yes	☐ No	Shingles/Chicken Pox	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Sickle Cell Disease/Traits	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Cancer/Chemotherapy	☐ Yes	☐ No	Hemophilia/Abnormal			Snoring/Sleep Apnea	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Bleeding	☐ Yes	☐ No	Stomach Problems/ Ulcers	☐ Yes	☐ No
Cold Sores/Herpes	☐ Yes	☐ No	Hepatitis A B C (circle)	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Colitis	☐ Yes	☐ No	High or Low Blood Pressure	☐ Yes	☐ No	Swollen Ankles	☐ Yes	☐ No
Contact Lenses	☐ Yes	☐ No	Hospitalized for Any Reason	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tuberculosis (TB)	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Diet (Special/Restricted)	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Venereal Disease/STD	☐ Yes	☐ No

Please list any serious medical condition(s) that you have ever had not listed above:

_____

Are you aware of having an allergic (or adverse) reaction to any of the following:

Aspirin	☐ Yes	☐ No	Iodine	☐ Yes	☐ No	Sedatives	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Jewelry/Metals	☐ Yes	☐ No	Sulfa Drugs	☐ Yes	☐ No
Anesthetics (i.e. Novocaine)	☐ Yes	☐ No	Latex	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No
Erythromycin	☐ Yes	☐ No	Penicillin or Other Antibiotics	☐ Yes	☐ No	Other _____		

Patient signature_____