

GALAXIA DENTAL

Today's Date: ___/___/___

Patient Information

Patient's Last Name _____ First Name _____ Middle Initial _____
 Date of Birth _____ Age _____ Male Female
 Address _____ City _____ State _____ Zip _____
 Telephone (Mobile) _____ (Home) _____ (Work) _____
 How did you hear about our office? _____

Parent/Guardian Information (If Patient is a minor)

Last Name _____ First Name _____ Middle Initial _____
 Relationship to Patient _____ Date of Birth _____
 Address (if different) _____ City _____ State _____ Zip _____
 Telephone (Mobile) _____ (Home) _____ (Work) _____
 Email Address _____

Insurance Information

Primary Insurance	Secondary Insurance
Policy Holder Name _____	Policy Holder Name _____
Date of Birth _____	Date of Birth _____
Relationship to Patient Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Relationship to Patient Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____
Insurance Company _____	Insurance Company _____
Member ID _____	Member ID _____
Group Number _____	Group Number _____
Employer _____	Employer _____
Insurance Phone Number _____	Insurance Phone Number _____

Emergency Contact Name _____ Relationship _____ Phone _____

Consent for Initial Exam

I consent to the diagnostic procedures necessary to perform an Initial Exam, which may include any necessary radiographs, intra-oral/extra-oral exam.

Signature (responsible party if patient is a minor) _____ Date _____

Dental History

Reason for Today's Visit _____

Are you currently experiencing dental pain or discomfort? Yes No (If yes, Where) _____

Are there any other concerns we should be aware of? _____

When did you last visit a Dentist? _____

	Yes	No	Don't Know
Do your gums bleed when you brush or floss?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your Mouth Dry?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear Dentures or Partials?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How do you feel about your smile? _____

Patient's Last Name _____ First Name _____ DOB ____ / ____ / ____ Today's Date ____ / ____ / ____

Patient Medical History

Are you under the care of a Physician now? Yes No Physician's name _____

Have you every been hospitalized or had a major operation/surgery? Yes No

If yes, Please Explain _____

Have you every had a serious head or neck injury? Yes No If yes, Please Explain _____

Please list any medications that you are currently taking

Medication	Dosage	How Often	Route (Oral / Injection etc)

Do you use tobacco? (smoking, snuff, chew, bidis) Yes No

Do you drink Alcoholic beverages? Yes No If yes, about how many drinks per week? _____

Do you use controlled substances? Yes No

Are you Allergic to any of the following? Latex Local Anesthetic Penicillin Aspirin Codeine Metal
 Sulfa Drugs Acrylic Other _____

Women Only- Are you Pregnant? Yes No Number of weeks _____ Nursing? Yes No Taking birth control pills? Yes No

Medical History - Do you have or have you had any of the following?

- | | | | | | |
|------------------------------|--|---------------------------|--|---|--|
| Artificial Heart Valve | Yes <input type="checkbox"/> No <input type="checkbox"/> | Dizzy / Fainting Spells | Yes <input type="checkbox"/> No <input type="checkbox"/> | Psychiatric Care | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Artificial Joints | Yes <input type="checkbox"/> No <input type="checkbox"/> | Down Syndrome | Yes <input type="checkbox"/> No <input type="checkbox"/> | Rheumatic Fever | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| AIDS / HIV | Yes <input type="checkbox"/> No <input type="checkbox"/> | Emphysema | Yes <input type="checkbox"/> No <input type="checkbox"/> | Scarlet Fever | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Anemia | Yes <input type="checkbox"/> No <input type="checkbox"/> | Epilepsy / Seizures | Yes <input type="checkbox"/> No <input type="checkbox"/> | Shortness of Breath | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Angina / Chest Pains | Yes <input type="checkbox"/> No <input type="checkbox"/> | Frequent Cough | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sickle Cell Anemia | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Arthritis, Rheumatism | Yes <input type="checkbox"/> No <input type="checkbox"/> | Glaucoma | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sinus Trouble | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Asthma | Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Attack / Failure | Yes <input type="checkbox"/> No <input type="checkbox"/> | Skin Rash | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| - (required hospitalization) | Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> | Stroke | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Autism | Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Murmur | Yes <input type="checkbox"/> No <input type="checkbox"/> | Swelling of feet or ankles | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Bleeding / Clotting Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Valve Prolapse | Yes <input type="checkbox"/> No <input type="checkbox"/> | Thyroid Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Blood Disorder | Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Pacemaker | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tonsillitis | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Birth Defect | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hepatitis (type _____) | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tuberculosis | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Bronchitis | Yes <input type="checkbox"/> No <input type="checkbox"/> | Herpes | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tumor/ growth (head/neck) | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cancer | Yes <input type="checkbox"/> No <input type="checkbox"/> | High Blood Pressure | Yes <input type="checkbox"/> No <input type="checkbox"/> | Ulcers | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cerebral Palsy | Yes <input type="checkbox"/> No <input type="checkbox"/> | High Cholesterol | Yes <input type="checkbox"/> No <input type="checkbox"/> | Unexplained weight loss | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Chemo / Radiation Therapy | Yes <input type="checkbox"/> No <input type="checkbox"/> | Immune Deficiency | Yes <input type="checkbox"/> No <input type="checkbox"/> | Any other serious illness not listed above? | _____ |
| Cold Sores / Fever Blisters | Yes <input type="checkbox"/> No <input type="checkbox"/> | Jaundice | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | _____ |
| Congenital Heart Disorder | Yes <input type="checkbox"/> No <input type="checkbox"/> | Kidney Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | _____ |
| Convulsions | Yes <input type="checkbox"/> No <input type="checkbox"/> | Low Blood Pressure | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | _____ |
| Diabetes | Yes <input type="checkbox"/> No <input type="checkbox"/> | Osteoporosis / Osteopenia | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | _____ |

The Information I have given is correct to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes in my/my child's health and/or medications. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me/my child. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

Patient's Signature _____ Date ____ / ____ / ____
 (Parent / Legal Guardian if Patient is a minor)