

Shuayb Dental
229 Mariner Blvd
Spring Hill FL 34609

Patient Information

First name _____ last name _____ preferred name _____

Address _____ city _____ state _____ zip _____

Home phone # _____ CELL # _____ work # _____

Social Security Number _____ Date of birth _____ EMAIL _____

Emergency contact name _____ phone # _____

Who referred you to our office? _____

Dental History

Date of last cleaning _____ date of last x-rays _____

Explain the reason for your visit today _____

Are you experiencing any discomfort yes no

Does dental treatment make you nervous yes no

Do you snore yes no

Do you have bleeding gums yes no

Do you have bad breath yes no

Do you grind your teeth yes no

Do you use an athletic mouth guard yes no

Are you sensitive to hot, cold or sweets yes no

Have you been treated for periodontal or gum disease yes no

Do you use mouthwash yes no

Do you use tobacco yes no

Interested in having whiter\brighter teeth yes no

If you could change your smile, what would you change _____

Do you wear a denture or partial yes no how old is your denture or partial _____

Are your dentures loose yes no

Physician name _____ phone # _____

Medical History

- Are you under a physician's care yes no
- Have you ever been hospitalized or had a major operation yes no
- Have you had a serious head or neck injury yes no
- Women: are you pregnant, trying to get pregnant or nursing yes no

Please check any conditions that you currently or previously have had:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Aids\HIV positive | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Arthritis\Gout | <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Artificial joint |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood disease | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Breathing problem |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Chest pains |
| <input type="checkbox"/> Cold sores\fever blisters | <input type="checkbox"/> Congenital heart disorder | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Easily winded | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy or seizures |
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Fainting spells\dizziness | <input type="checkbox"/> frequent cough | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Heart attack\failure | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> Heart trouble\disease | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Herpes | <input type="checkbox"/> Hives or rash | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Pain in jaw joints |
| <input type="checkbox"/> Parathyroid disease | <input type="checkbox"/> Pins, rods, stints or shunts | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Recent weight loss | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Sinus problem | <input type="checkbox"/> Stomach\intestinal disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling of limbs | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors or growths | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal disease |

Are you ALLERGIC or do you react adversely to any of the following

- | | | | |
|--|--|--------------------------------------|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Acrylic | <input type="checkbox"/> sulfa drugs | <input type="checkbox"/> Penicillin or antibiotics |
| <input type="checkbox"/> Metal | <input type="checkbox"/> barbiturates or sedatives | <input type="checkbox"/> codeine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Tetracycline | | |

Other _____

List all medications you are currently taking _____

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any change in my health or medication at each visit.

Signature of patient or guardian

Date