**Dr. Curtis Roy & Assoc.**
3703 Johnston Street
Lafayette, LA 70503

# Patient Information

**Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.**

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (it different): _____ City: _____ State: _____ Zip: _____

Home phone _____ Cell: _____ E-mail: _____ Driver's license #: _____ State: _____

SS #: _____ Employer: _____ Bus. Phone: _____

Spouse's name & phone #: _____

Person to contact in case of emergency: _____ Phone: _____

Primary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____

## Dental Health History

| | Yes | No |
|---|---|---|
| Are you apprehensive about dental treatment? | ☐ | ☐ |
| Have you had problems with previous dental treatment? | ☐ | ☐ |
| Do you gag easily? | ☐ | ☐ |
| Do you wear dentures? | ☐ | ☐ |
| Does food catch between your teeth? | ☐ | ☐ |
| Do you have difficulty in chewing your food? | ☐ | ☐ |
| Do you chew on only on one side of your mouth? | ☐ | ☐ |
| Do you avoid brushing any part of your mouth because of pain? | ☐ | ☐ |
| Do your gums bleed easily? | ☐ | ☐ |
| Do your gums bleed when you floss? | ☐ | ☐ |
| Do your gums feel swollen or tender? | ☐ | ☐ |
| Have you ever noticed slow-healing sores in or about your mouth? | ☐ | ☐ |
| Are your teeth sensitive | ☐ | ☐ |
| Do you feel twinges of pain when your teeth come in contact with: | | |
| Hot foods or liquids? | ☐ | ☐ |
| Cold foods or juices? | ☐ | ☐ |
| Sours? | ☐ | ☐ |
| Sweets? | ☐ | ☐ |
| Do you take fluoride supplements? | ☐ | ☐ |
| Are you dissatisfied with the appearance of your teeth? | ☐ | ☐ |
| Do you prefer to save your teeth? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Do you want complete dental care? | ☐ | ☐ |
| How often do you brush? | ☐ | ☐ |
| How often do you floss? | ☐ | ☐ |
| Does your jaw make noise so that it bothers you or others? | ☐ | ☐ |
| Do you clench or grind your jaws frequently? | ☐ | ☐ |
| Do your jaws ever feel tired? | ☐ | ☐ |
| Does your jaw get stuck so that you can't open freely? | ☐ | ☐ |
| Does it hurt when you chew or open wide to take a bite? | ☐ | ☐ |
| Do you have earaches or pain in front of the ears? | ☐ | ☐ |
| Do you have any jaw symptoms or headaches upon awaking in the morning: | ☐ | ☐ |
| Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? | ☐ | ☐ |
| Do you find jaw pain or discomfort extremely frustrating or depressing? | ☐ | ☐ |
| Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants) | ☐ | ☐ |
| Do you have a temporomandibular (jaw) disorder (TMD)? | ☐ | ☐ |
| Do you have pain in the face, cheeks, jaws, joints, throat, or temples? | ☐ | ☐ |
| Are you unable to open your mouth as far as you want? | ☐ | ☐ |
| Are you aware of an uncomfortable bite? | ☐ | ☐ |
| Have you had a blow to the jaw (trauma)? | ☐ | ☐ |
| Are you a habitual gum chewer or pipe smoker? | ☐ | ☐ |

*(Continued on side 2)*

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# Medical Health History

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

| | Yes | No |
|---|---|---|
| Heart Problems | ☐ | ☐ |
| Chest pain | ☐ | ☐ |
| Shortness of breath | ☐ | ☐ |
| Blood pressure problem | ☐ | ☐ |
| Heart murmur | ☐ | ☐ |
| Heart valve problem | ☐ | ☐ |
| Taking heart medication | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ |
| Pacemaker | ☐ | ☐ |
| Artificial heart valve | ☐ | ☐ |
| Blood Problems | ☐ | ☐ |
| Easy bruising | ☐ | ☐ |
| Frequent nosebleed | ☐ | ☐ |
| Abnormal bleeding | ☐ | ☐ |
| Blood disease (anemia) | ☐ | ☐ |
| Ever require a blood transfusion? | ☐ | ☐ |
| Allergy Problems | ☐ | ☐ |
| Hay fever | ☐ | ☐ |
| Sinus problems | ☐ | ☐ |
| Skin rashes | ☐ | ☐ |
| Taking allergy medication | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Intestinal Problems | ☐ | ☐ |
| Ulcers | ☐ | ☐ |
| Weight gain or loss | ☐ | ☐ |
| Special diet | ☐ | ☐ |
| Kidney or bladder problems | ☐ | ☐ |
| Bone or Joint Problems | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Back or neck pain | ☐ | ☐ |
| Joint replacement (e.g., total hip, pins, or implants) | ☐ | ☐ |
| Fainting Spells, Seizures, or Epilepsy | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Frequent or severe headaches | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ |
| Persistent cough or swollen glands | ☐ | ☐ |
| Premedications required by physician | ☐ | ☐ |
| Cancer (Tumor) | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Urinate more than 6 times a day | ☐ | ☐ |
| Thirsty or mouth is dry much of the time | ☐ | ☐ |
| Family history of diabetes | ☐ | ☐ |
| Tuberculosis or other respiratory disease | ☐ | ☐ |
| Do you drink alcohol? | ☐ | ☐ |
| If so, how much? _____ | | |
| Do you smoke? | ☐ | ☐ |
| If so, how much? _____ | | |
| Hepatitis, jaundice, or liver trouble | ☐ | ☐ |
| Herpes or other STD | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| HIV positive/AIDS | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Do you wear contact lenses? | ☐ | ☐ |
| History of head injury? | ☐ | ☐ |
| Epilepsy or other neurological disease? | ☐ | ☐ |
| History of alcohol or drug abuse? | ☐ | ☐ |
| Do you have any disease, condition, or problem not listed previously that you feel we should know about? | ☐ | ☐ |

If so, please describe: _____

**Are you allergic, or have you reacted adversely, to any of the following?**

| | | |
|---|---|---|
| Local anesthetic (Novocaine) | ☐ | ☐ |
| Penicillin or other antibiotics | ☐ | ☐ |
| Sulfa drugs | ☐ | ☐ |
| Barbiturates, sedatives or sleeping pills | ☐ | ☐ |
| Aspirin, Acetaminophen, or Ibuprofen | ☐ | ☐ |
| Codeine, Demerol, or other narcotics | ☐ | ☐ |
| Reaction to metals | ☐ | ☐ |
| Latex or rubber gloves | ☐ | ☐ |
| Other _____ | | |

**During the past 12 months, have you taken any of the following:**

| | | |
|---|---|---|
| Antibiotics or sulfa drugs | ☐ | ☐ |
| Anticoagulants (i.e., Coummadin) | ☐ | ☐ |
| High blood pressure medicine | ☐ | ☐ |
| Tranquilizers | ☐ | ☐ |
| Insulin, Orinase, or similar drug | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Digitalis or drugs for heart trouble | ☐ | ☐ |
| Nitroglycerin | ☐ | ☐ |
| Cortisone (steroids) | ☐ | ☐ |
| Natural remedies | ☐ | ☐ |
| Nonprescription drug/supplements | ☐ | ☐ |
| Other _____ | | |

**Women**

| | | |
|---|---|---|
| Are you taking contraceptives or other hormones? | ☐ | ☐ |
| Are you pregnant? | ☐ | ☐ |
| If so, expected delivery date _____ | | |
| Are you nursing? | ☐ | ☐ |
| Have you reached menopause? | ☐ | ☐ |
| If so, do you have any symptoms? _____ | | |

**PLEASE BE AWARE THAT YOU ARE RESPONSIBLE FOR ANY BALANCE THAT IS NOT PAID BY YOUR INSURANCE COMPANY.**

The above information is true and complete to the best of my knowledge. I agree to pay my co-payment at the time services are rendered. The Doctor is not responsible for completion of treatment if I consistently fail to keep scheduled appointments. I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

**Patient Signature** (Parent's signature, if a minor) _____ Date_____

**Please indicate if you have taken any of the below mentioned medications**

**in the past or if you are currently taking these medications.**

| | Yes | No |
|---|---|---|
| **Pamidronate (Intravenous)** (**Aredia,** Novartis) | _____ | _____ |
| **Zoledronate (Intravenous)** (**Zometa,** Novartis) | _____ | _____ |
| **Etidronate (Oral, Intravenous)** (**Didronel,** Proctor & Gamble) | _____ | _____ |
| **Risedronate (Oral)** (**Actonel,** Proctor & Gamble) | _____ | _____ |
| **Tiludronate (Oral)** (**Skelid,** Sanofi) | _____ | _____ |
| **Alendronate (Oral)** (**Fosamax,** Merck) | _____ | _____ |
| **Ibandronate (Oral, Intravenous)** (**Boniva,** Hoffmann-La Roche) | _____ | _____ |

***"Because you are taking a type of drug called a bisphosphonate, you may be at risk for developing osteonecrosis of the jaw and certain dental treatments may increase that risk."***

**Please list all medications you are currently taking (both prescribed and over the counter). Use reverse side for additional space.**

_____

_____

_____

_____

_____

_____ **Date** _____

**Patient's Signature** **(I have read and understand the above information)**