GALLIGAN FAMILY DENTISTRY

Preventive & Orthodontic Care for Kids & Adults

Welcome and thank you for choosing Galligan Family Dentistry. We want your visit with us to be a pleasant, comfortable, and safe experience. Please help us achieve this goal by providing the following information:

Patient Information

Name: _____
Last First Middle Nickname

Address: _____
Street

_____
City State Zip Code

Employer: _____ Driver's License Number: _____

Date of Birth: _____ Social Security Number: _____

Phone: Home: _____ Work: _____

Mobile: _____

Email: _____

Emergency Contact: _____ _____
Name Phone Number

Insurance Information

Primary Insurance: _____ Primary Insurance Phone: _____

Subscriber Name: _____ Relationship: □ Self □ Spouse □ Dependent □ Other

Subscriber #/SS#: _____ Employer: _____ Group Number: _____

Do you have other coverage: □ Flex Spending Account □ Health Savings Account □ Secondary Insurance

Other Information

How did you hear about us? □ Drive-By □ Mailer Sent to Home □ At Work □ School/Preschool

□ Internet □ Apartment Office □ Neighborhood Club/Office □ Insurance Website □ Newspaper

Who may we thank for referring you? _____

Do you have any special concerns that we need to be aware of? _____

What are your interests or hobbies? _____

Dental History

What is the primary reason for today's visit? _____

Is there anything specifically we can do to help make your experience with us exceptional? _____

_____

Bite (Occlusion)

Do your teeth *improperly* fit together when you bite? □ Yes □ No

Do you have a history of broken teeth? □ Yes □ No

Have you gone a prolonged period with missing teeth? □ Yes □ No

Are your front teeth: □ Crowded □ Chipped □ Worn □ Thin

Teeth (Dentition)

Are any teeth sore or painful when chewing? □ Yes □ No

Are any teeth sensitive to hot, cold, or sweet foods/drinks? □ Yes □ No

Do your teeth trap food? □ Generalized □ Specific Area

Gums (Periodontium)

Do your gums hurt or bleed when brushing, flossing, eating? □ Yes □ No

Do you find it difficult to manage bad breath? □ Yes □ No

Do you feel any teeth becoming mobile? □ Yes □ No

Smile (Esthetics)

Are you concerned about your front teeth: □ Color □ Size □ Shape □ Length

Are your teeth crowded, spaced, or misaligned? □ Yes □ No

Are you concerned with the appearance of existing restorations? □ Yes □ No

Bite and Smile Improvements

Would you like to review orthodontic treatment for straightening your smile, improving oral hygiene, and protecting your bite from excessive wear or broken teeth? □ Yes □ No

Are you interested in lifetime whitening or other treatment options to improve your smile? □ Yes □ No

Would you like to review missing teeth replacements to prevent further teeth breakdown? □ Yes □ No

Please note anything else that you would like to discuss about your bite, teeth, gums, or smile? _____

_____

Medical History

Please realize that many medications that you may be using and health conditions you may have could make a significant difference in how we treat your dental needs. We ask that you assist us in maintaining our effort for optimal and safe dental care by completing the following information as thoroughly as possible. Furthermore, we genuinely care about your overall health and aim to do our part to support and enhance your well-being. Thank you.

Medications

Please list all prescribed medications as well as over-the-counter medications you are routinely taking and reason for their use (please provide a separate list if extensive).

_____

_____

Allergies

Please indicate any drug or material allergies and specify by name (antibiotic, narcotic pain medication, latex, etc.):

_____

General

Do you require antibiotic pre-medication before dental treatment? □ Yes □ No

Have you been hospitalized in the past 2 years? Reason: _____ □ Yes □ No

Do you smoke or use tobacco? □ Yes □ No

Year Diagnosed: _____

Cardiovascular

□ High Blood Pressure

□ Rheumatic Fever

□ Artificial Heart valve

□ Congenital Heart Defect

□ Heart Attack – Year: _____

□ Congestive Heart Failure

□ Angina/Chest pain

□ Pace Maker

Hematologic

□ Anemia

□ Hemophilia

□ Blood Thinner: □ Aspirin □ Coumadin □ Plavix □ Other

□ Hepatitis: □ A □ B □ C □ D

Pregnancy

□ Currently pregnant – Weeks: _____

□ Nursing

□ Currently taking birth control

Endocrine

□ Diabetes: Please circle: □ Type I □ Type II

□ Thyroids □ Hypo □ Hyper

□ Adrenal Disorder

□ Transplant – Organ: _____ Year: _____

□ Hormone Replacement – Hormone: _____

Cancer

What Type: _____

Neurologic

□ Frequent Headaches

Most common time of day: _____

Typical trigger: _____

□ Stroke – Year: _____

□ Epilepsy/Seizures – Trigger: _____

□ Psychiatric Disorder – Type: _____

□ History of Drug or Alcohol Abuse

□ Bulimia or Anorexia

Pulmonary

□ Tuberculosis (TB)

□ Asthma

□ Chronic Bronchitis, COPD, Emphysema

Genitourinary

□ Kidney Failure – Dialysis days: _____

□ STD – Type: _____

□ HIV/AIDS

Miscellaneous

□ Artificial Joint □ Knee □ Hip □ Other

□ Arthritis – □ Osteo □ Rheumatoid

□ Fever Blisters/Cold Sores

□ TMD

□ Sjogrens Disease

□ Gastric Reflux (GERD)

□ Chronic Dry Mouth (Xerostomia)

□ Other conditions we should be aware of:

_____

_____

Thank you for taking the time to provide us with this information. We will input this data into your chart and request your signature electronically during your appointment