



GALLIGAN FAMILY DENTISTRY

Caring for Every Smile, Every Generation.

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 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

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: _____
Year Diagnosed: _____

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:

I authorize Dr. Abigail Scanlan and staff to perform radiographs (x-rays), photographs, and/or other routine diagnostic procedures necessary to make a thorough diagnosis of my dental needs.

I have received a copy of Galligan Family Dentistry's HIPAA privacy practices.

I acknowledge that the information provided here is as complete as possible and to the best of my knowledge.

Patient Name

Signature (Patient/Legal Guardian)

Date