MATUS
FAMILY DENTISTRY

PATIENT INFORMATION

Name_____ Birth Date_____ SS#_____

Address_____ City_____ State_____ Zip Code_____

Sex: ☐M ☐F Marital Status: ☐Single ☐Married ☐ Divorced ☐ Widowed ☐Minor ☐Other

Home phone_____ Cell phone_____ Email _____

Employer/School _____ Employer/School phone _____

Person to contact in case of emergency_____Phone_____

Whom may we thank for referring you? _____

DENTAL HISTORY

What is the reason for your visit today? _____

Date of last dental visit_____Date of last dental x-rays _____

How often do you brush?_____How often do you floss?_____

Are you experiencing any pain now? ☐ Yes ☐ No

If yes, explain_____

Are you anxious about dental treatment? ☐ Yes ☐ No

What concerns do you currently have with your oral health or smile? (check all that apply)

☐ Bleeding gums	☐ Unhappy with appearance of teeth	☐ Hot/cold sensitivity
☐ Discolored teeth	☐ Clenching/grinding of teeth	☐ Overbite/underbite
☐ Crooked teeth	☐ Food gets caught between teeth	☐ Uncomfortable bite
☐ Missing teeth	☐ Spaces in between teeth	☐ Old fillings or crowns
☐ Loose teeth	☐ Difficulty chewing	☐ Bad breath

☐ Other _____

Have you ever had orthodontic treatment? ☐ Yes ☐ No If yes, when? _____

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings or surgery? ☐ Yes ☐ No

Have you been told you need to take antibiotics prior to dental treatment? ☐ Yes ☐ No

If yes, please give name and dose_____

MEDICAL HISTORY

1. Do you have any health problems? Yes No
   If yes, please describe_____
2. Have there been any changes to your health in the past year? Yes No
3. Are you currently under medical care? Yes No
   If yes, for what? _____
4. Are you taking any medications, pills or drugs? Yes No If yes, please list on attached form.
5. Have you had an orthopedic total joint replacement? Yes No Date?_____
6. Have you taken bisphosphonate agents for osteoporosis, Paget's disease, cancer treatments or hypercalcemia (ex. Alendronate, Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia, Aredia, Zometa)? Yes No

7. WOMEN ONLY:
   Are you pregnant? Yes No Are you taking birth control pills/hormonal replacement? Yes No
   Are you nursing? Yes No

8. Do you have any of the following allergies? ☐ No known allergies
   ☐ Aspirin ☐ Codeine ☐ Dental anesthetics (novocaine) ☐ Other_____
   ☐ Metals ☐ Latex ☐ Penicillin/amoxicillin

9. Do you have or have you ever had any of the following?

Artificial heart valve	Yes	No
Damaged valves in transplanted heart	Yes	No
Repaired congenital heart disease with residual defects	Yes	No
Previous infective endocarditis	Yes	No
Unrepaired, cyanotic congenital heart disease	Yes	No
CHD repaired completely in the last 6 months	Yes	No

10. Do you currently have of have you ever had any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Cardiovascular disease	☐	☐	STDs	☐	☐	GI Disease	☐	☐
Angina	☐	☐	HIV/AIDS	☐	☐	Reflux/Heartburn	☐	☐
Arteriosclerosis	☐	☐	Chronic cold sores	☐	☐	Osteoporosis	☐	☐
Congestive heart failure	☐	☐	Arthritis	☐	☐	Chronic pain	☐	☐
Damaged heart valves	☐	☐	Autoimmune disease	☐	☐	Muscular disorder	☐	☐
Heart attack	☐	☐	Rheumatoid arthritis	☐	☐	Liver disease	☐	☐
Heart murmur	☐	☐	Lupus	☐	☐	Hepatitis A, B, or C	☐	☐
Chest pain w/ exertion	☐	☐	Asthma	☐	☐	Epilepsy	☐	☐
High blood pressure	☐	☐	Bronchitis	☐	☐	Fainting	☐	☐
Congenital heart defect	☐	☐	Emphysema	☐	☐	Neurological disorders	☐	☐
Stroke	☐	☐	Tuberculosis	☐	☐	Multiple sclerosis	☐	☐
Pacemaker	☐	☐	Sinus trouble	☐	☐	Psychiatric disorders	☐	☐
Blood transfusion	☐	☐	Cancer	☐	☐	Autism spectrum	☐	☐
Rheumatic fever	☐	☐	Sleep apnea	☐	☐	ADHD/ADD	☐	☐
Kidney problems	☐	☐	Headaches/migraines	☐	☐	Abnormal bleeding	☐	☐
Diabetes type I or II	☐	☐	Tobacco use	☐	☐	Blood disorders	☐	☐
Thyroid problems	☐	☐	Alcohol abuse	☐	☐	Hemophilia	☐	☐
Eating disorder	☐	☐	Drug use/abuse	☐	☐	Other: _____		

MATUS
FAMILY DENTISTRY

CURRENT MEDICATION LIST

Patient Name:_____ Date:_____

Medication	Reason Taking	How much	How often
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

The above information is true to the best of my knowledge. I hereby grant Samantha C. Matus, DMD and associates, 1067 Farmington Avenue, Berlin, CT 06037, to administer any treatment agreed upon or to administer such anesthetics and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

_____ _____

Signature of Patient/Legal Guardian Samantha C. Matus, DMD

HEALTH INFORMATION UPDATE (DO NOT COMPLETE ON FIRST VISIT)
I have reviewed and updated my patient information sheet and recorded any changes.

Patient's Signature _____ Date _____

_____ _____

_____ _____

_____ _____