



# General Information

J. Thaddeus Morgan, D.M.D.

Email:

Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Cell Phone: <i>Include area code</i> (    )	Would you like to receive Text Notifications? YES <input type="checkbox"/> NO <input type="checkbox"/>
Name: <i>Last:</i> <i>First:</i> <i>Middle:</i>	Home Phone: <i>Include area code</i> (    )
Address:	City:                      State:                      ZIP:
DOB:                      Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	SSN or Patient ID:
Occupation:	Business Phone: <i>Include area code</i> (    )
Emergency Contact:                      Relationship:	Cell Phone: <i>Include area code</i> (    )
If you are completing this for someone else, what is your relationship to the patient?	
<i>Name:</i>	<i>Relationship:</i>
Preferred Pharmacy:	Best way to contact: Cell <input type="checkbox"/> / Home Phone <input type="checkbox"/> / Business Phone <input type="checkbox"/> / E-mail <input type="checkbox"/> <i>(Check all that apply)</i>

## Dental Insurance:

Insurance Company: \_\_\_\_\_

Employer: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_

## Do you have any of the following diseases or problems?

*(Check DK if you Don't Know the answer to the question)*

**YES NO DK**

Active Tuberculosis .....

Persistent cough greater than 3 week duration .....

Cough that produces blood.....

Been exposed to anyone with tuberculosis.....

***If you answer YES to any of the 4 items above, please stop and return this form to the receptionist***



# Dental Information

J. Thaddeus Morgan, D.M.D.

	YES	NO	DK		YES	NO	DK
Do you have dental implants? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you under going IVF treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, when placed: _____				Have you ever had Orthodontic (braces) treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, surgeon who placed: _____				Have you had adverse reactions to dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you brush or floss? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please explain: _____			
Are your teeth sensitive to cold, hot, or sweet? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	You are experiencing any dental pain today?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have neck or ear pain?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had Periodontal (gums) surgery? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you know if you clench or grind your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any current sores or ulcers in your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you trying to get pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unable for Radiographs (x-rays)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date of last cleaning? \_\_\_\_\_

What is the reason for your dental visit today? \_\_\_\_\_

For the following questions, please mark (X) your responses to the following questions.

Do you take medications for:	YES	NO	DK		YES	NO	DK
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Narcotics for Pain Management .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please List: _____				Blood Thinners (Anti-Coagulants) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis (at any time).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppression (Steroids) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please List: _____				High Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of Last Dose: _____							

Because these medical conditions affect your oral health, please be as complete as possible

Please place an (X) for any condition listed below:

	YES	NO	DK		YES	NO	DK
Cardiovascular Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmias .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there regurgitation: .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Last Viral Load Test: _____ Result: _____			
Autoimmune Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or AIDS Related Complex: .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____				Symptoms _____			
Systemic Lupus .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, Jaundice, Disease of Liver.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type _____			
Sinus Issue .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Chemotherapy/Radiation .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear a CPAP or Mouth Appliance? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____				Persistence Swollen Glands .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe Headaches / Migraines .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type 1 <input type="checkbox"/>							
Type 2 <input type="checkbox"/>							
Last A1C _____							

Patient Signature: \_\_\_\_\_ Doctor Signature: \_\_\_\_\_



Name of Physician:

Because these medical conditions affect your oral health, please be as complete as possible

Please place an (X) for any condition listed below:

Joint Replacement?

YES NO DK

Have you ever had an Orthopedic joint (hip, knee, spine, elbow, finger) replacement?.....

Specify: \_\_\_\_\_ Date: \_\_\_\_\_ Surgeons Name and Number: \_\_\_\_\_

Are you taking or have you taken in last 3 years Bisphosphonate (Fosamax, Actonel, Boniva, Reclast, Prolia) for Osteoporosis: .....

Date treatment began: \_\_\_\_\_ Are you still taking? YES / NO Date last dose: \_\_\_\_\_

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?.....

Date treatment began: \_\_\_\_\_

Any Medical Condition NOT listed: \_\_\_\_\_

YES NO DK

Do you smoke or use tobacco? .....

Do you drink? .....

Approx how many times a week? \_\_\_\_\_

Do you Vape or use Vaping products? .....

Do you take Medical Marijuana?.....

Have you had a serious illness in the past 5 years?.....

Specify: \_\_\_\_\_

Please list medications taken: \_\_\_\_\_

YES NO DK

High Blood Pressure.....

Chest Pain on Exertion .....

Rheumatic Fever .....

Anemia .....

Blood Transfusion .....

Date: \_\_\_\_\_

Hemophilia .....

Arthritis .....

Asthma .....

Bronchitis.....

Tuberculosis .....

Chronic Pain .....

Diagnosed Condition: \_\_\_\_\_

Eating Disorder .....

Ulcers.....

Thyroid Issue.....

Hyper .....

Hypo.....

Glaucoma.....

Epilepsy.....

Fainting or Seizures .....

Neurological Disorders.....

Specify: \_\_\_\_\_

Mental Health Disorder.....

Specify: \_\_\_\_\_

Recurrent Infections.....

Type: \_\_\_\_\_

Kidney Problems.....

Sexually Transmitted Disease .....

Excessive Urination .....

Any condition NOT listed: \_\_\_\_\_

Allergies?

YES NO DK

Local Anesthetics .....

Aspirin .....

Penicillin or Antibiotics .....

Sulfa Drugs .....

Iodine.....

Metals .....

Latex .....

Codeine or Other Narcotics .....

Other Allergies .....

Artificial (prosthetic heart valve) .....

Previous Infective Endocarditis.....

Damaged Valves in Transplanted Heart .....

Congenital Heart Disease (CHD).....

Unrepaired, Cyanotic CHD .....

Repaired (completely) in Last 6 Months.....

Repaired CHD with Residual Defects.....

Angina .....

Arteriosclerosis .....

Congestive Heart Failure .....

Damaged Heart Valve.....

Low Blood Pressure .....