# 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: *Include area code*
( )

Would you like to receive Text Notifications?
YES ☐ NO ☐

Name:
*Last:* *First:* *Middle:*

Home Phone: *Include area code*
( )

Address: City: State: ZIP:

DOB: Sex: Male ☐ Female ☐ SSN or Patient ID:

Occupation: Business Phone: *Include area code*
( )

Emergency Contact: Relationship: Cell Phone: *Include area code*
( )

If you are completing this for someone else, what is your relationship to the patient?

*Name:* *Relationship:*

Preferred Pharmacy: Best way to contact: Cell ☐ / Home Phone ☐ / Business Phone ☐ / E-mail ☐
*(Check all that apply)*

## 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 that 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 |
|---|---|---|---|
| Do you have dental implants? | ☐ | ☐ | ☐ |
| If so, when placed: _____ | | | |
| If so, surgeon who placed: _____ | | | |
| Do your gums bleed when you brush or floss? | ☐ | ☐ | ☐ |
| Are your teeth sensitive to cold, hot, or sweet? | ☐ | ☐ | ☐ |
| Is your mouth dry? | ☐ | ☐ | ☐ |
| Have you ever had Periodontal (gums) surgery? | ☐ | ☐ | ☐ |
| Are you pregnant? | ☐ | ☐ | ☐ |
| Are you trying to get pregnant? | ☐ | ☐ | ☐ |

| | YES | NO | DK |
|---|---|---|---|
| Are you under going IVF treatment? | ☐ | ☐ | ☐ |
| Have you ever had Orthodontic (braces) treatment? | ☐ | ☐ | ☐ |
| Have you had adverse reactions to dental treatment? | ☐ | ☐ | ☐ |
| If so, please explain: _____ | | | |
| You are experiencing any dental pain today? | ☐ | ☐ | ☐ |
| Do you have neck or ear pain? | ☐ | ☐ | ☐ |
| Do you know if you clench or grind your teeth? | ☐ | ☐ | ☐ |
| Do you have any current sores or ulcers in your mouth? | ☐ | ☐ | ☐ |
| Unable for Radiographs (x-rays)? | ☐ | ☐ | ☐ |

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 |
|---|---|---|---|
| Diabetes | ☐ | ☐ | ☐ |
| Mental Health | ☐ | ☐ | ☐ |
| *Please List:* _____ | | | |
| Osteoporosis (at any time) | ☐ | ☐ | ☐ |
| *Please List:* _____ | | | |
| *Date of Last Dose:* _____ | | | |

| | YES | NO | DK |
|---|---|---|---|
| Epilepsy | ☐ | ☐ | ☐ |
| Narcotics for Pain Management | ☐ | ☐ | ☐ |
| Blood Thinners (Anti-Coagulants) | ☐ | ☐ | ☐ |
| Immunosuppression (Steroids) | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ |

***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 |
|---|---|---|---|
| Cardiovascular Disease | ☐ | ☐ | ☐ |
| Arrhythmias | ☐ | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ | ☐ |
| Mitral Valve Prolapse | ☐ | ☐ | ☐ |
| *Is there regurgitation:* | ☐ | ☐ | ☐ |
| Autoimmune Disease | ☐ | ☐ | ☐ |
| *Specify:* _____ | | | |
| Systemic Lupus | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| Sinus Issue | ☐ | ☐ | ☐ |
| Cancer/Chemotherapy/Radiation | ☐ | ☐ | ☐ |
| *Specify:* _____ | | | |
| Diabetes | ☐ | ☐ | ☐ |
| *Type 1* ☐ *Type 2* ☐ | | | |
| *Last A1C* _____ | | | |

| | YES | NO | DK |
|---|---|---|---|
| Gastrointestinal Disease | ☐ | ☐ | ☐ |
| G.E. Reflux | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ |
| HIV | ☐ | ☐ | ☐ |
| *Last Viral Load Test:* _____ *Result:* _____ | | | |
| AIDS or AIDS Related Complex: | ☐ | ☐ | ☐ |
| *Symptoms* _____ | | | |
| Hepatitis, Jaundice, Disease of Liver | ☐ | ☐ | ☐ |
| *Type* _____ | | | |
| Sleep Disorder | ☐ | ☐ | ☐ |
| *Do you wear a CPAP or Mouth Appliance?* | ☐ | ☐ | ☐ |
| Persistence Swollen Glands | ☐ | ☐ | ☐ |
| Severe Headaches / Migraines | ☐ | ☐ | ☐ |

Patient Signature: _____ Doctor Signature: _____

# Medical Information

*J. Thaddeus Morgan, D.M.D.*

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:** _____

_____

**Allergies?**

| | YES | NO | DK |
|---|---|---|---|
| Local Anesthetics | ☐ | ☐ | ☐ |
| Aspirin | ☐ | ☐ | ☐ |
| Penicillin or Antibiotics | ☐ | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ | ☐ |
| Iodine | ☐ | ☐ | ☐ |
| Metals | ☐ | ☐ | ☐ |
| Latex | ☐ | ☐ | ☐ |
| Codeine or Other Narcotics | ☐ | ☐ | ☐ |
| Other Allergies | ☐ | ☐ | ☐ |

| | YES | NO | DK |
|---|---|---|---|
| Artificial (prosthetic heart value) | ☐ | ☐ | ☐ |
| 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 | ☐ | ☐ | ☐ |

| | 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: _____

_____

**NAME:**

**DATE:**

**ARE YOU CURRENTLY ON ANY MEDICATIONS?** **YES ____ or No____**

| Name of Medication | Frequency | Physician Who Prescribed | Notes |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |