pickle prosthodontics

B. Todd **Pickle,** DDS, MS, FACP, PC

*Thank you* **for filling out this form completely.**

**It will enable our office to be more effective in meeting your needs.**

**If you have questions at any time, please ask us. We will be happy to help.**

Name:_____

Today's Date:____/____/____ Birthdate: ____/____/____ Home Phone Number: (____) _____

Cell Phone Number: (____) _____ Email _____

# Dental History

**Why have you come to the dentist today?** _____

_____

**Are you happy with the way your smile looks?** ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you experienced problems associated with any previous dental work? ❑ Yes ❑ No

Do you have frequent headaches? ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in your jaw (TMJ / TMD)? ❑ Yes ❑ No

Your current health is ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

How long do you use a toothbrush before replacing it?_____

Do you use anything in addition to your toothbrush and floss? ❑ Yes ❑ No

If yes, what?_____

Have you ever had periodontal disease? ❑ Yes ❑ No

Do you have any teeth that are loose? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else?_____

Have you lost any teeth? ❑ Yes ❑ No

If yes, why?_____

Do you have dentures or partials? ❑ Yes ❑ No

If yes, when did you get the first one?_____

Do you need to be premedicated before dental work? ❑ Yes ❑ No

## Dental Treatment

❑ Ready to start today

❑ Ready to start within the next month

❑ Ready to start in the next 90 days

❑ Gathering information

Previous/Present Dentist:_____

# Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:_____

Address:_____

_____

City State Zip

Phone #: (____)_____ Date of last visit:_____

**Your current physical health is:** ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Do you smoke or use tobacco in any form? ❑ Yes ❑ No

Do you smoke or use marijuana in any form? ❑ Yes ❑ No

**Are you allergic to any of the following?**

| | | |
|---|---|---|
| Y N **Aspirin** | Y N **Erythromycin** | Y N **Sedatives** |
| Y N **Barbiturates** | Y N **Jewelry** | Y N **Sulfa Drugs** |
| Y N **Codeine** | Y N **Latex** | Y N **Tetracycline** |
| Y N **Dental Anesthetics** | Y N **Penicillin** | Y N **Other** |

Please list additional drugs that cause allergic reactions: _____

_____

**For Women:** Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? Week # _____ ❑ Unsure ❑ Yes ❑ No

Are you nursing? ❑ Yes ❑ No

## Are you taking any of the following medications?

| | | | | | |
|---|---|---|---|---|---|
| Acetaminophen | ❑ Yes ❑ No | Blood Pressure Medication | ❑ Yes ❑ No | Nitroglycerin | ❑ Yes ❑ No |
| Antibiotics | ❑ Yes ❑ No | Cold Remedies | ❑ Yes ❑ No | Oral / IV Bisphosphonates | ❑ Yes ❑ No |
| Antihistamines | ❑ Yes ❑ No | Digitalis / Heart Medication | ❑ Yes ❑ No | Recreational Drugs | ❑ Yes ❑ No |
| Aspirin | ❑ Yes ❑ No | Homeopathic & Supplements | ❑ Yes ❑ No | Steroids / Cortisone | ❑ Yes ❑ No |
| Blood Thinners | ❑ Yes ❑ No | Insulin / Diabetes Drugs | ❑ Yes ❑ No | Thyroid Medicine | ❑ Yes ❑ No |
| | | | | Tranquilizers | ❑ Yes ❑ No |

Are you taking any prescription/over-the-counter drugs not listed above? ❑ Yes ❑ No

Please list the names of all medications that you are currently taking: _____

_____

_____

_____

**CONTINUED ON BACK**

# Medical History

Have you experienced any of the following diseases or medical problems?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Y N | **Abnormal Bleeding** | Y N | **Emphysema** | Y N | **Pacemaker** |
| Y N | **Acid Reflux** | Y N | **Epilepsy** | Y N | **Persistent Cough** |
| Y N | **Alcohol Abuse** | Y N | **Fever Blisters / Herpes** | Y N | **Psychiatric Problems** |
| Y N | **Anemia** | Y N | **Frequent Headaches** | Y N | **Radiation Treatment** |
| Y N | **Arthritis** | Y N | **GI Problems** | Y N | **Rheumatic Fever** |
| Y N | **Artificial Bones / Joints** | Y N | **Glaucoma** | Y N | **Scarlet Fever** |
| Y N | **Artificial Valves** | Y N | **Hay Fever** | Y N | **Seizures** |
| Y N | **Asthma** | Y N | **Heart Attack** | Y N | **Severe Headaches** |
| Y N | **Blood Transfusion** | Y N | **Heart Murmur** | Y N | **Shingles** |
| Y N | **Cancer** | Y N | **Heart Surgery** | Y N | **Sickle Cell Disease** |
| Y N | **Chemotherapy** | Y N | **Hepatitis** | Y N | **Sinus Problems** |
| Y N | **Chicken Pox** | Y N | **High Blood Pressure** | Y N | **Sleep Disorders/Apnea** |
| Y N | **Colitis** | Y N | **HIV + / AIDS** | Y N | **Steroid Therapy** |
| Y N | **Congenital Heart Defect** | Y N | **Hospitalized For Any Reason** | Y N | **Stroke** |
| Y N | **COVID19** | Y N | **Kidney Problems** | Y N | **Thyroid Problems** |
| Y N | **COVID19 Vaccine** | Y N | **Liver Disease** | Y N | **Tonsillitis** |
| Y N | **Diabetes** | Y N | **Low Blood Pressure** | Y N | **Tuberculosis (TB)** |
| Y N | **Difficulty Breathing** | Y N | **Mitral Valve Prolapse** | Y N | **Ulcers** |
| Y N | **Drug Abuse** | Y N | **Osteoporosis** | Y N | **Venereal Disease** |

Please list any serious medical condition(s) that you have experienced: _____

_____

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____
Signature Date

I understand that I am responsible for payment of treatment at time of service and Dr. Pickle does not accept assignment of benefit from any insurances. I also understand that my insurance will be filed at the time of service and payments will be made directly to me.

_____
Signature Date

## OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials:_____ Date:_____

Doctor's Comments:_____

_____

_____

## MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it accurately states past and present medical conditions.

**Patient Comments:**

_____
Patient Signature Date

_____
Doctor Signature Date

I have read my medical history dated _____ and confirmed that it accurately states past and present medical conditions.

**Patient Comments:**

_____
Patient Signature Date

_____
Doctor Signature Date

I have read my medical history dated _____ and confirmed that it accurately states past and present medical conditions.

**Patient Comments:**

_____
Patient Signature Date

_____
Doctor Signature Date