FIELD DENTISTRY, DMD, PA

Theodore S. Field, III, DMD · Anthony M. Lewis, DDS
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Welcome to our office! We are looking forward to you joining our dental family of friends. It is our goal to help you achieve both ideal dental health and the impeccable smile you want and deserve. Please complete this form so that we may provide you with the best possible care. Thank you!

Date: _______________ Whom may we thank for referring you to our office? _______________

Personal Information

Dr. Mr. Mrs. Ms. Miss	Patient's Full Name	Suffix: Sr. Jr. III IV
Sex	Age	Date of Birth
Home Street Address		Apartment #
City	State	Zip Code
Home Phone #	Cell Phone #	E-Mail Address

Employment Information

Occupation	Employer Name	
Work Street Address		Suite #
City	State	Zip Code
Work Phone #	Cell Phone #	E-Mail Address

Other Information

When is the best time to contact you?	At which phone # ?

Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed Spouse's Name:___________________

In case of emergency:

Contact Name	Relationship	Phone #

Medical History

Primary Care Physician Name City State Office Phone #

Date of Last Medical Exam: ____________________

How would you rate your current state of medical health? ( ) Excellent ( ) Good ( ) Fair ( ) Poor

Do you smoke or use smokeless tobacco? ( ) Yes ( ) No If yes, how often? ____________________

Are you currently taking any prescription or non-prescription medications? ( ) Yes ( ) No

If yes, please list (or provide a list) the name, dosage, and purpose of each medication:

Medication Name	**Dosage**	**Purpose**

Do you have, have you had, or have you ever been treated for any of the following medical conditions?

Yes	**No**	Heart Attack/Stroke	**Yes**	**No**	Heart Murmur/Rheumatic Fever
Yes	**No**	Hepatitis/Jaundice	**Yes**	**No**	High/Low Blood Pressure
Yes	**No**	Epilepsy/Seizures/Fainting	**Yes**	**No**	Abnormal Bleeding
Yes	**No**	Cancer/Chemotherapy	**Yes**	**No**	Kidney Disorders
Yes	**No**	Psychiatric Disorders	**Yes**	**No**	Type I Diabetes/Type II Diabetes
Yes	**No**	Tuberculosis/Pneumonia	**Yes**	**No**	Drug/Alcohol Abuse
Yes	**No**	Anemia	**Yes**	**No**	HIV/AIDS

If you have ever been treated for any other medical condition/illness not listed above, please explain:

If you have ever had surgery of any kind, please explain:

If you have been diagnosed/treated for any medical condition within the last 5 years, please explain:

Do you need to be pre-treated with antibiotics prior to dental treatment? ( ) Yes ( ) No

Are you allergic to any of the following medications?

Yes	**No**	Penicillin	**Yes**	**No**	Aspirin	**Yes**	**No**	Sulfa Drugs
Yes	**No**	Erythromycin	**Yes**	**No**	Codeine	**Yes**	**No**	Local Anesthetic

If you are allergic to any other medications, please explain:

FEMALE PATIENTS ONLY:

Are you pregnant? ( ) Yes ( ) No If yes, how many months? ______________

Are you planning to get pregnant? ( ) Yes ( ) No If yes, when? ______________

Dental History

Why have you come to see Dr. Field or Dr. Lewis today? ______________________________________

Many patients consult us for a second opinion. Is this true in your case? ( ) Yes ( ) No
If yes, please explain below:

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How would you describe the condition of your teeth and gums? ( ) Excellent ( ) Good ( ) Fair ( ) Poor

When was the date of your last dental visit? __________________________

What was the name of your previous dentist? __________________________

Are you currently experiencing and pain/discomfort with your teeth and gums? ( ) Yes ( ) No
If yes, please explain below:

____

If you could wave a magic wand and change anything about your smile what would you like to do?

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How often do you brush your teeth? ________________ How often do you floss? ________________

Do you use a mouth rinse?	**Yes**	**No**	
Do your gums bleed when you brush or floss your teeth?	**Yes**	**No**	
Would you be interested in safely bleaching your teeth?	**Yes**	**No**	
Do you grind/clench your teeth?	**Yes**	**No**	**Don't Know**
Have you ever experienced pain in your jaw joints?	**Yes**	**No**	
Have you ever been treated for TMJ symptoms?	**Yes**	**No**	

If yes please explain below:

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The information that I have provided to Dr. Field and Dr. Lewis is correct to the best of my knowledge. I understand that any and all information will be held in the strictest of confidence and used only to improve professional communications between other doctors, their staff, and myself. I also give my permission to Dr. Field, Dr. Lewis, and their staff to professionally utilize any necessary photographs taken in conjunction with my treatment.

____
Patient's (Legal Guardian) Signature Date

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Dentist's Signature Date