Fred C. Burnham, D.M.D.
Kyle D. Gagliardo, D.D.S.
Patient Information

Name____ Sex (M/F)______
First M.I. Last

If Child, Parents' Names ____

Street Address ____

City______________________ State__________ Zip____________ Today's Date__________________

Phone: Home______________________ Work______________________ Cell______________________

Date of Birth ____________ Social Security #________________ Driver's License #____________________

Responsible Party For Account________________________________ Employer______________________

Covered By Dental Insurance? (Y/N)______ Insurance Company______________________________

Yes	No	Does your medical history include any of the following conditions?
___	___	Have you been hospitalized in the last five years? Why? ______________________________
___	___	Do you have high blood pressure?
___	___	Do you have an abnormal heart condition?______________________________
___	___	Do you have a heart murmur?
___	___	Do you have any artificial joints or valves?
___	___	Have you had rheumatic fever or rheumatic heart disease?
___	___	Do you have or are you at risk for AIDS?
___	___	Are you allergic to any medications? List______________________________
___	___	Are you allergic to metal, acrylic, or latex?
___	___	Have you had any abnormal bleeding from a cut or trauma?
___	___	Do you have convulsions or epilepsy?
___	___	Are you diabetic?
___	___	Do you have hepatitis or liver disease?
___	___	Have you ever had a stroke?
___	___	Do you have tuberculosis?
___	___	Do you have asthma?
___	___	Women: Are you pregnant or trying to become pregnant?
___	___	Do you have any other medical problem not mentioned above?

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(continue on other side)

Please list any medications you are currently taking, including blood thinners, herbal medicines, and birth control:

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Yes	No	Dental Questions
___	___	Do your gums bleed easily?
___	___	Are your teeth sensitive to hot/cold?
___	___	Are you currently having dental pain?
___	___	Do you have any oral lumps or sores?
___	___	Do you use tobacco?
___	___	Do you bleed excessively after extractions?
___	___	Do you have frequent headaches?
___	___	Have you had any jaw or neck injuries?
		Have you experienced any of the following jaw problems?
___	___	Clicking sounds when you open or close
___	___	Pain (joint, ear, side of face)
___	___	Difficulty in opening or closing
___	___	Difficulty chewing
___	___	Grinding or clenching your teeth
___	___	Do you wear a nightguard/occlusal splint?
___	___	Have you ever had braces?
___	___	Do you like your smile? If not, what would you change? ______________________

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What is your main concern, or what would you like to have done today? ______________________

______________________When was your last dental visit?______________________

I was referred by ____

Physician's Name/Phone Number ____

In case of emergency, contact ____

Patient or Guardian's Signature ____

(continue on next page)