Jennifer Pichardo, DDS, PC

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Name_____
Home Address_____
City, State Zip_____
Email Address _____

Date of Birth _____
Social Security Number_____
Phone Number _____
Preferred Contact Method: Call/Text/Email

Patient Medical History

1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operation or serious illness? Yes No
3. Are you taking any medication(s) including non-prescription medicine? Yes No
If yes, which medication(s)? _____
4. Do you use tobacco? Yes No
5. Do you use alcohol? Yes No
6. Do you use cocaine? Yes No
7. Do you use other drugs? Yes No
8. Which ones? _____
9. Are you wearing contact lenses? Yes No
10. Are you allergic to or have you had any reactions to:

Local Anesthetics (e.g. Novocain)	Yes	No
Penicillin or other antibiotics	Yes	No
Sulfa Drugs	Yes	No
Barbiturates	Yes	No
Sedatives	Yes	No
Iodine	Yes	No
Aspirin	Yes	No
Other	Yes	No

11. *Women Only:*

a) Are you pregnant?	Yes	No
b) Are you nursing?	Yes	No
c) Are you taking birth control pills?	Yes	No

12. Do you have or have you had any of the following? (Circle which apply)

High Blood Pressure	Heart Attack
Rheumatic Fever	Swollen Ankles
Fainting/Seizures	Asthma
Low Blood Pressure	Leukemia
Epilepsy/Convulsions	Diabetes
Kidney Diseases	AIDS/HIV
Thyroid Problem	Heart Disease
Cardiac Pacemaker	Heart Murmur
Frequently Tired	Angina
Emphysema	Anemia
Cancer	Arthritis
Hepatitis/Jaundice	Chest Pains
Stomach Troubles/Ulcers	Stroke
Sexually Transmitted Disease	Glaucoma
Hay Fever/Allergies	Easily Winded
Joint Replacement/Implant	Tuberculosis
Radiation Therapy	Liver Disease
Recent Weight Loss	Heart Trouble
Respiratory Problems	Other_____

Physician_____
Office Phone_____
Date of Last Exam_____
Pharmacy_____
Pharmacy Address_____
Pharmacy Phone_____
Emergency Contact Name_____
Emergency Contact Number_____

Patient Dental History

1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to hot or cold liquids/foods? Yes No
3. Are your teeth sensitive to sweet or sour liquids/foods? Yes No
4. Do you feel any pain to any of your teeth? Yes No
5. Do you have any sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck, or jaw injuries? Yes No
7. Have you ever experienced any of the following problems in your jaw? (Circle which apply)
a) Clicking?
b) Pain (joint, ear, side of face)?
c) Difficulty in opening or closing?
d) Difficulty in chewing?
8. Do you have frequent headaches? Yes No
9. Do you clench or grind your teeth? Yes No
10. Do you bite your lips or cheeks frequently? Yes No
11. Have you ever had any difficult extractions in the past? Yes No
12. Have you had any orthodontic work? Yes No
13. Have you ever had prolonged bleeding following extractions? Yes No
14. Have you ever had instruction on the correct method of brushing your teeth? Yes No
15. Have you ever had instructions on the care of your gums? Yes No

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered.

Signed_____ Date_____