WELCOME

Lulette A. Mercado DDS Family Dentistry

Patient Information
Must be fully completed.

Patient Name_____
Last **First** **MI**

Date of Birth_____ **Age**_____ **Social Security**_____
MM/DD/YYYY

Address_____
Street **City/ State** **Zip Code**

Email Address_____

Phone Number (____)_____ **(____)**_____
Primary **Secondary**

SEX- Male_____ Female_____

Married_____ Single_____ Divorced_____ Widwed_____ Minor_____

Employer_____

Employer Address_____
Street **City/State** **Zip Code**

Employer Phone Number (____)_____

Whom may we thank for referring you?_____

In case of an emergency who do we contact?
Name_____
Relationship_____ **Phone(___)**_____

Health History

Lulette A. Mercado DDS Family Dentistry

Please answer ALL questions

Place a check mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/ HIV	Yes	No	Nervous problems	Yes	No
Anemia	Yes	No	Pacemaker	Yes	No
Arthritis , Rheumatism	Yes	No	Psychiatric care	Yes	No
Artificial heart valves	Yes	No	Radiation treatment	Yes	No
Artificial joints	Yes	No	Respiratory	Yes	No
Asthma	Yes	No	Rheumatic fever	Yes	No
Back problems	Yes	No	Scarlet fever	Yes	No
Bleeding abnormally with extractions or surgery	Yes	No	Shortness of breath	Yes	No
Blood disease	Yes	No	Sinus trouble	Yes	No
Cancer	Yes	No	Skin rash	Yes	No
Chemical dependency	Yes	No	Special diet	Yes	No
Chemotherapy	Yes	No	Stroke	Yes	No
Circular problems	Yes	No	Swollen feet or ankles	Yes	No
Congenital heart lesions	Yes	No	Swollen neck glands	Yes	No
Cortisone treatments	Yes	No	Thyroid problem	Yes	No
Cough, persistent or bloody	Yes	No	Tonsillitis	Yes	No
Diabetes	Yes	No	Tuberculosis	Yes	No
Emphysema	Yes	No	Tumor or growth on the head or neck	Yes	No
Epilepsy	Yes	No	Ulcer	Yes	No
Fainting or dizziness	Yes	No	Venereal disease	Yes	No
Glaucoma	Yes	No	Weight loss, unexplained	Yes	No
Headaches	Yes	No	Do you wear contact lenses?	Yes	No
Heart murmurs	Yes	No	Are you pregnant?	Yes	No
Heart problems	Yes	No	Is yes, when is you due date?		
Hepatitis type ____	Yes	No	Taking birth controls pills?	Yes	No
Herpes	Yes	No	Are you nursing?	Yes	No
High blood pressure	Yes	No	Allergies:		
Jaundice	Yes	No	Aspirin	Yes	No
Jaw pain	Yes	No	Barbiturates (sleeping pills)	Yes	No
Kidney disease	Yes	No	Codeine	Yes	No
Liver disease	Yes	No	Iodine	Yes	No
Low blood pressure	Yes	No	Latex	Yes	No
Mitral valve prolapse	Yes	No	Local anesthetics	Yes	No
			Penicillin	Yes	No
			Sulfa	Yes	No
			Other		

List of any medications you are currently taking and the correlating diagnosis:_____

_____

_____

Dental History

Lulette A. Mercado DDS Family Dentistry
Please answer ALL questions.

Patient Name:_____

Reason for today's visit:_____

Former Dentist:_____
Name of Dr. **City/State**

Date of last dental visit:_____ **Date of last dental X-rays:**_____

Place a check mark on "yes" or "no" on all of the following questions.

Bad breath	**Yes**	**No**
Bleeding gums	**Yes**	**No**
Blisters on lips or mouth	**Yes**	**No**
Burning sensation on tongue	**Yes**	**No**
Chew on one side of the mouth	**Yes**	**No**
Cigarette, pipe, or cigar smoking	**Yes**	**No**
Clicking or popping of the jaw	**Yes**	**No**
Dry mouth	**Yes**	**No**
Finger nail biting	**Yes**	**No**
Food collection between the teeth	**Yes**	**No**
Foreign objects	**Yes**	**No**
Grinding of teeth	**Yes**	**No**
Gums swollen or tender	**Yes**	**No**
Jaw pain or tiredness	**Yes**	**No**
Lip or cheek biting	**Yes**	**No**
Loose teeth or fillings	**Yes**	**No**
Mouth breathing	**Yes**	**No**
Mouth pain while brushing	**Yes**	**No**
Orthodontic treatment	**Yes**	**No**
Pain around ear	**Yes**	**No**
Periodontal treatment	**Yes**	**No**
Sensitivity to sweets	**Yes**	**No**
Sensitivity when biting	**Yes**	**No**
Sores or growth	**Yes**	**No**
Sore or growths in your mouth	**Yes**	**No**

How often do you brush?_____