Dr. Dollins

Patient Information (confidential)

Date:_____

Name:_____ Birthdate_____Referred by:_____

Address_____City_____State_____Zip_____

HomePhone_____CellPhone_____Email_____

Occupation_____Employer_____Work Phone_____

Check Appropriate Boxes:☐Male☐Female☐Minor☐ Single☐Married☐Divorced☐Widowed☐Separated

Physician_____Phone_____Date of Last Exam_____

Person to contact in case of emergency_____Phone_____Relationship_____

Health Information :

Have you ever had any of the following? Please check those apply:

Y/N

☐☐AIDS/HIV
☐☐Anemia
☐☐Anxiety or excessive stress
☐☐Allergies_____
☐☐Arthritis
☐☐Artificial Joints/ Implants
☐☐Asthma
☐☐Back Pain or Sciatica
☐☐Bell's Palsy
☐☐Biphosphonates for Bone Loss
☐☐Birth Control Pills
☐☐Blood Disease
☐☐Cancer_____
☐☐Chemical Sensitivity
☐☐Chemotherapy
☐☐Chronic Bronchitis
☐☐Chronic Fatigue
☐☐Chronic Headaches
☐☐Chronic Muscle/Joint Pain
☐☐Circulatory Problems
☐☐Cough,persistent or bloody
☐☐Covid 19
☐☐Depression
☐☐Diabetes
☐☐Difficulty Sleeping
☐☐Drug Addiction
☐☐Eye Conditions
☐☐Emphysema
☐☐Endocarditis
☐☐Epilepsy
☐☐Excessive Bleeding
☐☐Fainting or dizziness
☐☐Frequent Sore throats
☐☐Frequent Urination
☐☐Glaucoma

Y/N

☐☐GI Disorders
☐☐Hay Fever
☐☐Headaches
☐☐Head Injuries
☐☐Heavy Metal Toxicity
☐☐Heart Attack
☐☐Heart Disease
☐☐Heart Murmur
☐☐Hepatitis Type_____
☐☐Herniated Disk
☐☐Herpes
☐☐High/Low Blood
☐☐High/Low Thyroid Hypoglycemia
☐☐Insomnia
☐☐Jaundice
☐☐Jaw Pain
☐☐Kidney Disorders
☐☐Low body temperature
☐☐Lymph Glands swell frequently
☐☐Palpitations
☐☐Premedicate
☐☐Pressure
☐☐Kidney Disease
☐☐Liver Disease
☐☐Lupus
☐☐Lyme's Disease
☐☐Mental Disorders
☐☐Mitral Valve Relapse
☐☐Multiple Sclerosis
☐☐Neck Pain
☐☐Nervous Disorders
☐☐Numbess fingers and toes
☐☐Osteoporosis/Osteopenia
☐☐Pacemaker

Y/N

☐☐Pregnancy
Due date:_____
☐☐Psychiatric/Emotional care
☐☐Rapid fatigue
☐☐Radiation Treatment
☐☐Rheumatic Fever
☐☐Rheumatism
☐☐Shaky Hands/Feet
☐☐Shortness of Breath
☐☐Short term memory loss
☐☐Skin Problems
☐☐Sinus Problems
☐☐Sleep Apnea
☐☐Special Diet _____
☐☐Snoring
☐☐Stroke
☐☐Swollen feet or Ankles
☐☐Swollen Neck Glands
☐☐Tingling in my body
☐☐Trouble making decisions
☐☐Tuberculosis
☐☐Twitching of Muscles
☐☐Tumors or
growth on head or neck
☐☐Ulcers
☐☐Urinary Troubles
☐☐Venereal Disease (STD)
☐☐Use Sugar Substitutes
☐☐Use Tobacco, pipe or cigar smoking
☐☐Use Recreational Drugs
☐☐Use Fen Phen
☐☐Use Hormones
☐☐Weight Loss,unexplained
☐☐Work around mercury

Allergies(Please list the response next to each allergy- i.e. rash, hives, anaphylaxis)

☐Acrylic ☐Latex ☐Sleeping Pills
☐Aspirin ☐Local Anesthetic ☐Sulfa Drugs
☐Codeine ☐Metal ☐Others_____
☐Iodine ☐Penicillin

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

Medication Name	Dosage	Diagnosis

(if any additional medications please attached a separate page)

Nutritional Supplements:☐None ☐Multivitamins ☐Trace Minerals ☐ EPA-DHA(Omega 3's)
☐Macro-Minerals(Zinc,Magnesium)☐Probiotics ☐Digestive Enzymes ☐AminoAcids ☐Antioxidants
☐Superfoods ☐Others_____

Are you under medical treatment right now?☐Yes ☐No
Have you ever been hospitalized for any surgical operation/serious illness within the last 5 yrs?_____
If yes, please explain _____
Are you wearing contact lenses? ☐Yes ☐No
Women only: a) are you pregnant or think you may be pregnant ☐Yes ☐No
b) Are you nursing? ☐Yes ☐No
c)Are you taking any contraceptives Yes ☐ No☐

Dental Information:

Reason for today's visit_____
Date of last dental visit:_____Date of last X-rays_____Date of Last Hygiene_____
Previous Dentist:_____City/State_____Reason for leaving:_____
Have you ever taken an antibiotic prior to dental treatment? ☐Yes ☐ No
Have you ever had any problem associated with dental anesthetic? ☐Yes ☐No

Y / N	Y / N	Y / N
☐☐Bad Breath	☐☐ Food collection between teeth	☐☐Pain around the ear
☐☐Bleeding Gums	☐☐Grinding Teeth	☐☐Periodontal treatment
☐☐Blisters on lips or mouth	☐☐Jaw pain or tiredness	☐☐Sensitivity to cold
☐☐Burning sensation on tongue	☐☐Lip or cheek biting	☐☐Sensitivity to heat
☐☐Chew on one side of mouth	☐☐Loose teeth or broken fillings	☐☐Sensitivity sweets
☐☐Clicking or popping jaw	☐☐Metallic taste	☐☐Sensitivity when biting
☐☐Dentures or partial	☐☐Mouth breathing	☐☐Sores or growths in your mouth
☐☐Dry mouth	☐☐Mouth pain, brushing	How often do you floss_____
☐☐Fingernail biting	☐☐Nightguard	How often do you brush?_____
☐☐Gum Swollen or tender	☐☐Orthodontic treatment	

Is having silver mercury fillings a concern for you? ☐Yes ☐No
Are you accustomed to seeing a dentist on a regular basis ? ☐Yes ☐No
Please rate your comfort level with receiving dental treatment: ☐No problem☐ Slight ☐Moderate
Please describe any problems you have had with past dental experiences _____

Is Biologic Dentistry (using materials that are compatible with your body)an interest to you? ☐Yes ☐ No
Do you believe that the health of the mouth can affect the health of the whole body? ☐Yes ☐ No