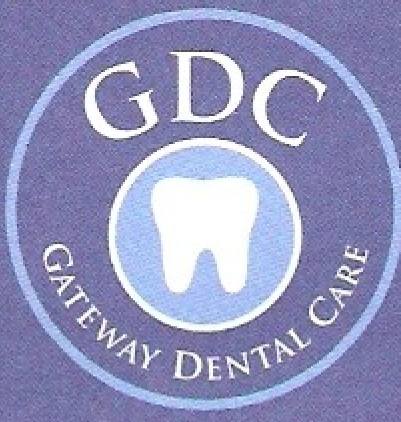

Patient Name ______________________________ Male Female

Legal Guardian Name (if patient is under 18) ______________________________

Date of Birth ____________ Social Security # ____________ Married Single

Address ______________________________ Apt # ____________

City ______________________ State ____________ Zip ____________

Telephone Numbers: Home ____________ Work ____________ Cell ____________

Email Address ______________________ Employer ______________________

Nearest relative not living with you:

Name ______________________ Address ______________________

City/State/Zip ______________________ Phone # ____________

How did you hear about your office? Check all that apply:

Friend/Relative (name) ______________________

Phone book _______ Mailer _______ Website _______ Drive By _______

Please tell us what services you are interested in: (circle all that apply)

Replacing silver fillings

Having a whiter smile

Oral Conscious Sedation

Tooth replacement (implants/bridge)

Smile Makeover

Straighter teeth

Please tell us of any other specific dental concerns you may have: ______________________

____

CONSENT TO PROCEED: I authorize Gateway Dental Doctors or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or any minor or other individual for which I have responsibility, including arrangements and/or administration of any sedative, restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include numbness, bruising and muscle soreness. I do voluntarily assume any and all risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired result, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions. Further, I understand that I am entering into a contractual relationship with the Gateway Dental Doctors for professional care. I further understand that meritless and frivolous claims for medical/dental malpractice have an adverse effect upon the cost and availability of healthcare, and may result in the irreparable harm to a healthcare provider. As additional consideration for professional care provided to me, I, the patient/guardian and or my representative agree not to advance, directly or indirectly, any false, meritless and/or frivolous claim(s) of medical/dental malpractice against Gateway Dental Doctors. Furthermore, should a meritorious medical/dental malpractice case or case of action be initiated of pursued, I and/or my representative agree to use expert witness(es) who practice primarily in the same specialty as Doctor. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Dental Association. In further consideration for this, Gateway Dental Doctors agree to the same stipulations.

______________________________ ____________

Signature of Patient, legal guardian or agent Date

Dr. Robert S. Salmans, DDS
2300 Gateway Dr. Wooster, OH 44691-5334 • PH: (330) 262-1121 • FAX: (330) 264-3711
WWW.DENTISTRYOFOHIO.COM

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ______________________

Phone #: (   ) ______________________

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No
Please explain: ______________________

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription/OTC drugs? ☐ Yes ☐ No

Please list each one: ______________________

Have you ever taken Phen-Fen? (or Redux) ☐ Yes ☐ No
If so, when? ______________________

Have you ever taken Fosamax? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control?

Are you pregnant? ☐ Yes ☐ No Week # ________

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal bleeding/hemophilia	Y	N	Herpes/Fever Blisters
Y	N	AIDS	Y	N	High Blood Pressure
Y	N	Alcohol/Drug Abuse	Y	N	HIV +
Y	N	Anemia	Y	N	Hospitalized
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Problems
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic/Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack/Heart Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical conditions that you have ever had:

____

____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Codeine
Y	N	Dental Anesthetics	Y	N	Erythromycin
Y	N	Jewelry/Metals	Y	N	Latex
Y	N	Penicillin	Y	N	Tetracycline
Y	N	Other			

Please list any other drugs/materials that you are allergic to:

____

____

DENTAL HISTORY

Why have you come to the dentist today? ______________________

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before treatment? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Med ☐ Soft

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold or anything else? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No

Whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change?

____

____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

____

Signature **Date**

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient named herein.

Initials: ______________________ **Date:** ______________________

Doctor's Comments:

____

____