ARCHIBALD
FAMILY DENTISTRY
18335 E. 103rd Ave, Ste 101
Commerce City, CO 80022
Phone: (303) 286-8700

Welcome to Archibald Family Dentistry. Thank you for choosing our dental healthcare team. ***To help us meet your dental needs, please fill out this form completely.***
If you have any questions or need assistance, please let us know. We look forward to assisting you and your family with all of your dental needs for a lifetime of smiles!

Patient Information

Name DOB SS #

Address City, State Zip

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated

Email Home Phone Cell Phone

Employer Work Phone

Business Address City, State Zip

Emergency Contact Relationship to Patient Phone

* Whom may we thank for referring you to our office?

Responsible Party **If same as above, check here** ☐

Name of Responsible Party Relationship to Patient

DOB SS#

Address City, State Zip

Email Daytime Phone Evening Phone

Employer Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of Insured Relationship to Patient

DOB SS# Date of Employment

Employer Work Phone

Address of Employer City, State Zip

Insurance Company Group # Policy/ID #

Insurance Address City, State Zip

Do you have additional insurance? ☐ **Yes** ☐ **No** **If yes, please complete the following:**

Name of Insured Relationship to Patient

DOB SS # Date of Employment

Employer Work Phone

Address of Employer City, State Zip

Insurance Company Group # Policy/ID #

Insurance Address City, State Zip

Patient Medical History

	Yes	No
1. Are you under the care of a physician?	☐	☐
2. Have you been hospitalized in the last five years? *If yes, please explain:* ______________________________	☐	☐
3. Are you taking any medications? *(Please include over-the-counter and prescription medications)* If yes, please list: ______________________________	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use alcohol?	☐	☐
6. Do you use cocaine or other drugs?	☐	☐
7. Do you wear contacts?	☐	☐
9. Have you ever had a reaction to anesthetic?	☐	☐
10. Are you allergic to latex or any medications? *If yes, please list:* ______________________________ ______________________________	☐	☐

Women only:

	Yes	No
11. Are you pregnant?	☐	☐
12. Are you nursing?	☐	☐
13. Are you taking birth control pills?	☐	☐

8. **Do you have or have you had any of the following? (Check all that apply)**

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Shortness of Breath	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other:	☐	☐

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in your mouth?	☐	☐
6. Have you ever suffered trauma to your face, mouth, or jaw?	☐	☐
7. Does your jaw ever click, pop, crackle, or ache?	☐	☐
8. Do you have pain in your jaw joint, ear, or side of the face?	☐	☐
9. Do you have difficulty opening or closing your mouth?	☐	☐
10. Do you have difficulty chewing?	☐	☐
11. Do you have frequent headaches?	☐	☐
12. Do you clench or grind your teeth?	☐	☐
13. Do you bite your lips or cheeks frequently?	☐	☐
14. Have you had problems with previous dental work?	☐	☐
15. Have you ever had braces?	☐	☐

16. How many times a day do you brush your teeth?___________

17. How often do you floss? ______________________________

18. Do you use a manual or electric brush?__________________

19. Do you use any type of mouth rinse?____________________

20. What are your goals for your mouth, teeth, and smile? *(Please use back side if necessary)*

* **If you could change anything about your smile, what would it be?**

Authorization and Release

I certify that I have read and understood the above information, and have answered every question completely and accurately, to the best of my knowledge. I understand that providing false or incorrect information can be dangerous to my health. I will inform my dentist of any change in my health and/or medication.

X____ ______________________________

Signature of patient (or parent/guardian if minor) *Date*