Dr. W. Day Gates III DMD MS
Prosthodontist
4464 Old Shell Rd.
Mobile, AL 36608
(251) 343-2163

Registration Information

Name: ______________________ ______________________ ______________________ _______
Last *First* *Middle* *Title (Mr, Mrs, Dr…)*

Date of Birth: ____/____/_______ Social Security Number: ___________________________

Street Address: ____
City: ____________________________ State: _______________ Zip Code: __________________

Phone Numbers:
Home: (_____)_________________
Work: (_____)_________________
Cell: (_____)_________________

Email: ________________________________

Employer: ____

Referred by: ____

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Dental History

Name: ______________________ ______________________ ______________________ _______
Last *First* *Middle* *Title (Mr, Mrs, Dr…)*

Date of Birth: ____/____/_______

Your answers to this dental history questionnaire will help us to understand your specific dental problems, so that we may more effectively treat you with consideration for your individual needs.

What is your immediate dental concern or reason for your visit today? ____

____

When was your last dental visit? ___________________ What was it for? ____

Previous General Dentist: _________________________________ Period of Treatment: _______________________________

Address: ____ Phone: ___________________

Dental Specialist: ____ Specialty: ____

Period of Treatment: ____ Date of Last Visit: __________________________________

Address: ____ Phone: ___________________

When was you last professional dental cleaning? ____

When was your last comprehensive dental exam? ____

Please check Yes or No

1. *Yes No* Are you presently in pain? If yes, please check all that apply
   - □ Teeth
   - □ Face
   - □ Gums
   - □ Jaw
   - □ Other: _____________________________

2. *Yes No* Is any part of your mouth sensitive to the following?
   - □ Cold
   - □ Hot
   - □ Sweet
   - □ Sour
   - □ Pressure
   - □ Other: _____________________________

3. *Yes No* Do you have a burning sensation in your mouth?
4. *Yes No* Are you troubled with dryness in your mouth?
5. *Yes No* Do you have any pain or soreness around your eyes, ears or other parts of your face?
6. *Yes No* Do you have chronic headaches or neckaches?
7. *Yes No* Does food catch between your teeth?
8. *Yes No* Are you aware of a bad taste or odor in your mouth?

9. *Yes No* Have you ever been informed that you have gum problems?
   If yes, By whom? ___________________________________ When? ___________________________________

10. *Yes No* Have you ever had periodontal treatment or gum surgery?
    If yes, By whom? ___________________________________ When? ___________________________________

11. *Yes No* Please indicate which items you use daily?

□ Hard-bristle toothbrush □ Proxi-brush □ Water spray
□ Soft-bristle toothbrush □ Rubber tip □ Stimudents or toothpicks
□ Electric toothbrush □ Dental Floss □ Other: ____________________________

12. *Yes No* Are you aware of any growths or swellings in your mouth?
If yes, please explain?____
____

13. *Yes No* Do you have frequent cold sores, canker sores or fever blisters on your gums, cheeks or lips?
If yes, how often?____

14. *Yes No* Are you aware of clenching your teeth during the day?
15. *Yes No* Have you ever been told you grind your teeth during sleep?
16. *Yes No* Do your jaw muscles feel tired, stiff or painful?
17. *Yes No* Does your jaw click, pop or make grating-like noises?

18. *Yes No* Are you dissatisfied with appearance of your teeth? If yes, please explain what you do not like. ________________
____
____

19. *Yes No* Do you have a removable denture or appliance?
   a. *Yes No* If yes, are you satisfied with your removable denture or appliance? If no, please explain dissatisfaction.
   ____
   ____

20. *Yes No* Are you anxious about dental treatment?

21. *Yes No* Have you experienced any problems with previous dental treatment?
If yes, please explain ____
____

22. *Yes No* Do you have any dental condition which was not addressed above that you feel is important for us to know?
If yes, please explain ____
____

To the best of my knowledge, all of the preceding answers are true and correct,

Signature: ____ *Date:* ________________________

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Medical History

Name: ______________________ ______________________ ______________________ ________
Last *First* *Middle* *Title (Mr, Mrs, Dr…)*

Date of Birth: ____/____/_______ Gender: *Male Female* Height: ________ Weight: _______

Marital Status: *Single Married*
Name of Spouse or Closest Relative: ____ Phone (_____)_____-___________
If you are completing this form for another person, what is your name and what is your relationship to that person?
____

The thoroughness of this medical history is designed for your safety, and complete answers will assist us in treating you with consideration for your special needs.

Primary Care Physician: ____________________________ Address: ____
Additional Physician: ______________________________ Address: ____
Additional Physician: ______________________________ Address: ____

For the following questions, please circle Yes or No, whichever applies.
Please note you will be asked about your responses to this questionnaire and there may be additional questions regarding your health.

1. *Yes No* Are you in good health?
2. *Yes No* Has there been any change in your general health within the last 2 years?
3. *Yes No* Are you now under the care of a Physician?
   If so, what is the condition being treated? ____
   ____
4. *Yes No* Have you had a serious illness, operation, or been hospitalized within the last 5 years?
   If yes, please explain ____
   ____
5. *Yes No* Surgery, radiation or other treatment for a tumor, growth, or cancer?
   If yes, please explain ____
6. *Yes No* Do you have a history of cardiovascular condition(s)? If yes, please check all that apply
   - □ Angina (Chest Pain)
   - □ Hypertension (High blood pressure)
   - □ Myocardial Infarction (Heart attack)
   - □ Atherosclerosis
   - □ Stroke
   - □ Pacemaker
   - □ Heart Murmur
   - □ Congenital Heart Defect
   - □ Endocarditis
   - □ Artificial/Prosthetic Heart Valve
   - □ Bypass
   - □ Other: _____________________________
7. *Yes No* Have you ever had a hip, knee, and/or other joint replaced?
8. *Yes No* Have you ever been advised to "pre-medicate" prior to dental treatment?
   If yes, please explain ____
9. Do you have or have you had any of the following conditions, symptoms, or diseases?
   a. *Yes No* Sinus trouble?
   b. *Yes No* Respiratory problems, Asthma, Emphysema, Bronchitis, etc…?
   c. *Yes No* Diabetes?
   d. *Yes No* Hepatitis, jaundice, liver disease, or decreased liver function?
   e. *Yes No* Kidney problems
   f. *Yes No* Stomach ulcer, hyperacidity, or gastric reflux

g. *Yes No* Persistent diarrhea or weight loss?
h. *Yes No* Arthritis or painful/swollen joints
i. *Yes No* Thyroid problems or abnormal function?
J. *Yes No* Depression or other mental health condition
k. *Yes No* Seizures, epilepsy, or other neurological condition
l. *Yes No* Tuberculosis (TB)
m. *Yes No* Persistent cough or cough that produces blood
n. *Yes No* Persistent swollen glands in your neck
o. *Yes No* Sexually transmitted disease
p. *Yes No* HIV infection or AIDS
q. *Yes No* Problems with your immune system
r. *Yes No* Blood disorders
s. *Yes No* Bleed excessively after being cut or bruised easily

9. *Yes No* Are you a former tobacco user? If yes, how long ago did you quit? ________________
10. *Yes No* Do you currently use tobacco products? If yes, please check all that apply
    □ Smoke
    □ Smokeless
    □ Other: ______________________
    How long have you used tobacco?________________
    How much tobacco do you use per day? ____________________
11. *Yes No* Do you consume alcohol? If yes, how many drinks do you have per week? ____________
12. *Yes No* Are you pregnant or nursing?
14. *Yes No* Do you have any allergies or had an allergic reaction? If yes, please check all that apply

	Please circle or describe reaction:				
□ Penicillin	*Rash*	*Hives*	*Trouble breathing*	*Nausea*	*Other:* _________________
□ Erythromycin	*Rash*	*Hives*	*Trouble breathing*	*Nausea*	*Other:* _________________
□ Other antibiotics	*Rash*	*Hives*	*Trouble breathing*	*Nausea*	*Other:* _________________
□ Sulfa drugs	*Rash*	*Hives*	*Trouble breathing*	*Nausea*	*Other:* _________________
□ Barbiturates or sedatives	*Rash*	*Hives*	*Trouble breathing*	*Nausea*	*Other:* _________________
□ Aspirin	*Rash*	*Hives*	*Trouble breathing*	*Nausea*	*Other:* _________________
□ Codeine	*Rash*	*Hives*	*Trouble breathing*	*Nausea*	*Other:* _________________
□ Other pain medication	*Rash*	*Hives*	*Trouble breathing*	*Nausea*	*Other:* _________________
□ Latex	*Rash*	*Hives*	*Trouble breathing*	*Nausea*	*Other:* _________________
□ Other: _____________	*Rash*	*Hives*	*Trouble breathing*	*Nausea*	*Other:* _________________

15. *Yes No* Are you currently taking or using any medications or drugs? (Please include herbal medications)
    If yes, please list medication and dosage below
    1) ____
    2) ____
    3) ____
    4) ____
    5) ____
    If you have additional medication please ask receptionist for additional paper or to photocopy medication list
16. *Yes No* Have you ever taken oral bisphosphonates (eg. Fosamax) or IV bisphosphonates?
17. *Yes No* Do you have any other condition, disease, or problem not mentioned or discussed?
    If yes, please explain ____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the provider at my next appointment. In addition, I grant permission for my physician(s) to be contacted for details and consultation.

Name: ____ Date: ____________________