Welcome to Dr. Luffey's Office!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you!

About You

Name: _____ Name I prefer to be called: _____
Last First Middle
□Female □Male Birth date: _____
Social Security Number: _____ Driver's License #: _____
Home Address_____
Mailing Address: _____
Home Phone #: _____ Cell #: _____Work #: _____
Email address: _____
What is the BEST way for us to confirm your appointments? _____

Spouse or Emergency Contact Information

Her/His Name: _____ Relationship: _____
Contact phone # _____ Alternate contact #: _____

Dental History

What is your reason for your upcoming dental appointment? _____
Are you currently in pain? □ Yes □ No Do you require antibiotics before dental treatment? □ Yes □ No
Do you floss daily? □ Yes □ No How many times per day do you brush? □ 0 □ 1 □ 2 □ 3 or more
What type of toothbrush do you use? □ Manual □ Battery □ Electric
Do your gums ever bleed? □ Yes □ No Do your gums ever itch or tingle? □ Yes □ No
Do you have any loose teeth? □ Yes □ No Have you ever had periodontal treatment? □ Yes □ No
Are your teeth sensitive to heat, cold or chewing? _____
Are you satisfied with the appearance of your teeth? □ Yes □ No If no, what would you like to change?
Length □ Yes □ No Shade □ Yes □ No Spaces □ Yes □ No Crowding □ Yes □ No
Other _____
Have you ever had any serious complications with prior dental treatment? ? □ Yes □ No
If yes, what? _____
Have you had any orthodontic work? □ Yes □ No Have you ever whitened your teeth? □ Yes □ No
If yes, what type of product? _____
Have you ever been in a car accident? □ Yes □ No
Are you fearful of dental procedures, needles or do you experience dental anxiety? □ Yes □ No
Other _____

Do you or have you ever smoked (cigars, cigarettes or pipe) or used smokeless tobacco? □ Yes □ No
If yes, how much, and how often? _____ If no, when did you quit? _____
Approximately how many alcoholic beverages do you presently consume per week?
□ None □ Less than 1 □ 1-5 drinks □ 6-11 drinks □ 11-20 drinks □ Over 20 drinks

Dental History (continued)

Have you ever experienced any of the following problems in your head, neck or jaw?

Clenching of teeth?	□ Yes □ No	Face pain?	□ Yes □ No	Neck injury?	□ Yes □ No
Clicking in jaw?	□ Yes □ No	Head injury?	□ Yes □ No	Pain (jaw, joint, ear, side of face)?	□ Yes □ No
Difficulty in chewing?	□ Yes □ No	Headaches?	□ Yes □ No		
Difficulty swallowing?	□ Yes □ No	Jaw pain or injury?	□ Yes □ No	Ringing in the ears?	□ Yes □ No
Difficulty opening or closing?	□ Yes □ No	Limited opening of mouth?	□ Yes □ No	Sleep problems?	□ Yes □ No

Medical History

Do you have a personal physician? □ Yes □ No Physician's Name: _____
Phone #: _____ Date of last visit? _____
Your current physical health is: □ Excellent □ Good □ Fair □ Poor
Are you required to pre-medicate before a dental visit? □ Yes □ No Reason? _____
Are you currently under the care of a physician? □ Yes □ No If yes, please explain: _____
Please list any medications, vitamins, herbs, etc., that you are taking. _____
_____
Do you have abnormal blood pressure? □ Yes □ No □ Unsure If yes, what is it usually? ____ s/ ____d
Women: Are you taking birth control pills? □ Yes □ No Depo-Provera? □ Yes □ No
Ortho-Evera? □ Yes □ No
Are you pregnant? □ Yes week # _____ □ No □ Unsure
Are you planning a pregnancy in the near future? □ Yes □ No

Do you or have you experienced the following?

Abnormal bleeding	□ Yes □ No	Hay fever	□ Yes □ No	Radiation treatment	□ Yes □ No
Anemia	□ Yes □ No	Herpes	□ Yes □ No	Recurrent illnesses	□ Yes □ No
Arthritis	□ Yes □ No	Heart (surgery, dis-		Rheumatic Fever	□ Yes □ No
Asthma	□ Yes □ No	ease, attack, artificial		Scarlet fever	□ Yes □ No
Blood Disorder	□ Yes □ No	valve, murmur)	□ Yes □ No	Seizures	□ Yes □ No
Cancer	□ Yes □ No	Hepatitis □A □ B	□ C □ No	Shingles	□ Yes □ No
Chemo therapy	□ Yes □ No	HIV infection/AIDS	□ Yes □ No	Sinus problems	□ Yes □ No
Circulatory problems	□ Yes □ No	Infections	□ Yes □ No	Slow healing mouth	
Diabetes	□ Yes □ No	Joint replacement	□ Yes □ No	sores	□ Yes □ No
Difficulty breathing	□ Yes □ No	Kidney problems	□ Yes □ No	Steroid therapy	□ Yes □ No
Emphysema or other		Liver disease	□ Yes □ No	Stroke	□ Yes □ No
respiratory problems	□ Yes □ No	Lupus	□ Yes □ No	Thyroid problems	□ Yes □ No
Epilepsy	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No	Tonsillitis	□ Yes □ No
Ever hospitalized	□ Yes □ No	Mouth biopsies	□ Yes □ No	Tuberculosis	□ Yes □ No
Fainting spells	□ Yes □ No	Pacemaker	□ Yes □ No	Unintentional	
Fever blisters	□ Yes □ No	Persistent cough	□ Yes □ No	weight gain/loss	□ Yes □ No
Glaucoma	□ Yes □ No	Psychiatric care	□ Yes □ No	Venereal Disease	□ Yes □ No

Are you allergic to any of the following?

Aspirin □ Yes □ No	Erythromycin □ Yes □ No	Latex □ Yes □ No	Sedatives □ Yes □ No
Codeine □ Yes □ No	Jewelry/Metals □ Yes □ No	Penicillin □ Yes □ No	Sulfa drugs □ Yes □ No

Authorization

I affirm that the information I have given is to the best of my knowledge. It is my responsibility to inform this office of any changes in address, insurance or medical status. I understand that I am responsible for payment of services rendered. As a courtesy, our office will file most insurances. I have received this office's Notice of Privacy Practices.

_____ _____
Signature Date