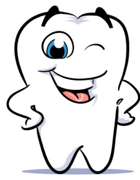

Welcome to Dr. McCuin's Office

Patient Information

Name:____
Address: _____________________________________
City: ____________________ State: _____ Zip _______
Home #:________________ Work#: _______________
Cell #: ________________ Date of birth: ___________
Referred by: __________________________________
S.S.# ____
Marital Status: (please circle one)
single married divorced separated widowed
Employed by: _________________________________
Occupation: __________________________________
Employment Address: ___________________________
City: ____________________ State: ____ Zip: ________

APPOINTMENTS: We require 24 hours notice if you cannot keep your scheduled appointment. A minimum charge will be made if you fail to notify us of cancellation. This fee covers only a portion of the overhead such as salaries, electric, heat etc., which still has to be paid whether you are present or not. Once you schedule an appointment remember that this time is reserved for you.

Signature: ______________________________

Date: _____________________

Dental History

Reason you came to see us today: ______________________
Last dental exam: _______________
Any previous major dental treatment? ____________________
If yes when: ____
Brief description: _____________________________________
What is the texture of your toothbrush? __________________
How often do you brush? _______________________________

Do you have or have you had any of the following?
Please mark only the ones that apply to you.

___ Teeth sensitive to cold, hot, sweet or pressure
___ Bleeding gums (How long) _______
___ Oral habits, i.e. fingernail biting, cheek biting, thumb sucking
___ Swelling or lumps in the mouth
___ Frequent blisters on lips or mouth
___ Unusual sounds in ear while eating
___ Unfavorable dental experience
___ Complications from extraction
___ Food Impaction
___ Clenching or grinding
___ Burning of the tongue
___ Mouth breathing
___ Orthodontic Treatment
___ Dental floss
___ Fluoride supplement
___ Pain around ear
___ Bad taste in mouth
___ Periodontal Treatment
___ Tobacco product use
___ Water jet device
___ Bad breath

Do you like the way your smile looks? _________________

If no, what would you like to change about it? ____________
____

Medical History

Physician's name: ________________________________
Date of last physical exam: _________________________

Have you ever been told you may need to be pre-medicated with antibiotics prior to dental treatment due to heart problems and/or joint replacements? ___________
If yes, for which condition? _________________________

Are you allergic to any medications? _________________
____

Do you currently have any of the following?
Please mark only the ones that apply to you

___ Allergies to anesthetics
___ Asthma
___ Heart valve disease
___ High blood pressure
___ Liver disease/hepatitis
___ Neurological problems
___ Malignances (cancer)
___ Radiation or chemo
___ Anemia or blood problems
___ Psychiatric care
___ Rheumatic fever
___ Sinus problems
___ Any heart ailments
___ General allergies
___ Diabetes
___ Stroke
___ Kidney disease
___ Thyroid
___ Eye Disorders
___ Tonsillitis
___ Tuberculosis
___ Ulcer or colitis
___ Arthritis
___ Pregnant
___ Excessive bleeding from cut or extraction?
___ Immune Disorder (AIDS, HIV, ARC ect)
___ Sleep Apnea