Dr. Gabriel F. Doria, DDS, LLC

Please fill out these forms completely to better serve you.

Patient Information

Name _____Date_____

Name you prefer to be called _____ DOB _____Age _____

Address_____City_____State_____Zip_____

Social Security#_____Single__Married__Partnered__Divorced__Widowed__

Home Phone _____Cell Phone_____

Business Phone _____ E-Mail_____

Occupation_____ Interests, sports, hobbies_____

Who may we thank for referring you? _____

Dental History

Date of Last Dental Examination _____Previous Dentist_____

Reason for Today's Visit_____

Please indicated any history of the following:	**Y**	**N**
Have you had any serious problems associated with dental treatment?		
Have you had any serious injury to your face, head or teeth?		
Are you currently experiencing pain in any part of your mouth?		
Are any of your teeth sensitive to hot, cold, sweets?		
Do your gums bleed when you brush?		
Do you have any loose or broken fillings?		
Do you have any loose or broken teeth?		
Do you clench or grind your teeth?		
Does your jaw click or pop?		
Have you ever had TMJ (jaw joint) problems?		
Do you experience bad breath?		
Does food collect between your teeth?		
Do you gag easily?		
Do you feel your teeth could be whiter?		
Do you snore, choke or have episodes of not breathing while you sleep?		
Do you frequently experience unrefreshing sleep?		
Do you feel nervous or anxious about dental treatment ?		

Please let us know if there is anything you would like to change about your smile:_____

Medical History

General Health: Excellent__ Good ___Fair ___ Poor__ Date of Last Physical Exam _____

Physician's Name _____ Phone_____

Address _____

Have you been admitted to a hospital or needed emergency care during the past two years?

Y__ N__ If yes, please explain _____

Are you currently under the care of a physician's? Y__N __Explain, if so_____

If you are currently using any medication or supplements, please list each one and the amount taken each day and reason for each:_____

Are you allergic to any of the following: Penicillin__Tetracycline __ Sulfa Drugs __ Aspirin __ Latex__

Please indicate any history of the following	Y	N
Blood pressure High Low		
Heart problems Please explain:		
Artificial Heart Valve		
Pacemaker		
Implanted Defibrillator		
Bleeding Disorder or Prolonged bleeding from extractions, surgery or trauma		
Arthritis		
Artificial Joints, Pins, etc.		
Diabetes		
Anemia		
Stroke		
Dizziness or Fainting		
Headaches		
Epilepsy, Seizures or Convulsions		
Lyme Disease		

	Y	N
Cancer or Malignancy		
Benign Tumors or Growths		
Radiation or Chemotherapy		
Gastrointestinal Disorders or Ulcers		
Kidney Disease		
Thyroid Disease		
Liver Disease or Hepatitis		
Hay fever, Asthma or Breathing Problems		
Sinus Problems		
Respiratory Disease or Disorder		
Hearing Loss		
Drug Addiction		
AID or HIV		
Eating Disorder		
Do you Smoke or Vape?		
Do you Use Chewing Tobacco?		
Do you Use Controlled Substances?		
Women only: Are you pregnant? If yes, what, month? ____		

Patients Signature_____ Date _____