Alina Davidson DDS, PLLC, “Passion for Dentistry”
Supplemental Patient Information

CONTACT INFORMATION

Patient’s Name (last, first, middle) _____

Date _____

Gender: ☐ M ☐ F Birth Date _____

Mailing Address _____ City _____ State ____
Zip _____

Social Security Number _____-_____-_____

Driver License Number _____ State _____

Home Phone _____ Work Phone _____ Cell _____

Email _____

Occupation _____

Employer/School _____

Employer/School Address _____ Phone _____

EMERGENCY CONTACT INFORMATION

Name_____

Relationship _____

Home Phone _____ Work Phone_____ Cell Phone _____

Presenting Complaint

Please use the space below to describe the reason for attending to our office

How did you hear about us?

☐ Social media ☐ In-home mailer ☐ Practice website ☐ Family/Friend

Preferred appointment days and times

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

☐ Morning ☐ Afternoon ☐ Evening ☐ Any time

Medical History

Primary Care Physician's (PCP) contact details:
- Name:
- Address:
- Phone number:

When was your last visit to your PCP?

Pre-medication: do you require a prophylactic medication prior to dental treatment? ☐ Yes ☐ No

Vitamins consumption: list all vitamins and nutritional supplements you take regularly

Pharmacy: please provide your pharmacy's contact details

Social History

- Are you single? ☐ Yes ☐ No
- Do you currently smoke cigarettes? ☐ Yes ☐ No
  - if yes, how many cigarettes per day?
- Do you currently vape? ☐ Yes ☐ No
  - if yes, how many times per day?
- Do you currently smoke cannabis? ☐ Yes ☐ No
  - if yes, how many cigarettes per day?

Diet History

- Do you consume still water? ☐ Yes ☐ No
  - if yes, how many liters/ounces per day?
- Do you consume soda? ☐ Yes ☐ No
  - if yes, how many per day?
- Do you consume fruit juices? ☐ Yes ☐ No
  - if yes, how many liters/ounces per day?

- Do you consume alcohol? ☐ Yes ☐ No
    - if yes, which type and how many alcoholic
        - how many drinks per day?
        - how many drinks per week?

- Do you cook at home? ☐ Yes ☐ No
    - if yes, how often?

- Breakfast: what do you usually consume for breakfast? Please list usual meals below
    -

- Lunch: what do you usually consume for lunch? Please list usual meals below
    -

- Dinner: what do you usually consume for dinner? Please list usual meals below
    -

- Do you snack between meals ☐ Yes ☐ No
    - if yes, please list how many times per day
        - what do you usually snack on?

Oral and Dental History

- Are you a regular attender of dental appointments?
- How often do you brush your teeth?
- Which type/brand of toothpaste do you use?
- Do you floss your teeth? ☐ Yes ☐ No
    - Which type of floss do you use?
- Do you use mouthwash? ☐ Yes ☐ No
    - How often?
    - Which brand of mouthwash do you use?

Lifestyle

- Do you exercise? ☐ Yes ☐ No
    - if yes, please describe your exercise routine
    - how often do you exercise per week?
    - Do you practice yoga? ☐ Yes ☐ No
        - If yes, how many times per week

Food Allergy/Sensitivity

- Please list any food allergies and sensitivities
    - if applicable, please describe what happens following consumption

Women Only

- Are you currently pregnant? ☐ Yes ☐ No
- Are you currently breastfeeding ☐ Yes ☐ No
- If you have given birth, was it (please check on) ☐ natural ☐ c-section

Additional Information

If you have additional information that you would like your doctor to know about you, please use this space (please write legibly)

Signature: _____ Date: _____