



Welcome and thank you for visiting Galligan Family Dentistry. We want your visit with us to be a pleasant, comfortable, and safe experience. Please help us achieve this by providing the following information.

Patient Information

Name _____
Last First Middle Nickname

Address _____
Street

_____ City State Zipcode

Employer _____ Drivers License Number _____

Date of Birth _____ Social Security Number _____

Phone: Home (____) _____ Subscriber Soc. Security Number _____

Work (____) _____ Email: _____

Mobile (____) _____

Emergency Contact _____ (____) _____
Name Phone Number

Insurance Information

Primary Insurance Co. _____ Group Number _____

Subscriber Name _____ Employer _____

Do you have a Flex Spending Account, Health Savings, Account, or Secondary Insurance? – Please circle if yes.

Other Information

How did you hear about us?...

Mailer Sent to Home At Work School/Preschool Internet Apartment Office

Neighborhood Club/Office Insurance Website Newspaper Other

Who may we thank for referring you? _____

Do you have any special concerns that we need to be aware of? _____

What are your interests or hobbies? _____

Dental History

What is the primary reason for today's visit? _____

Is there anything specifically we can do to help make your experience with us exceptional? _____

What are your feelings about the following:

Front Teeth: Are you happy with their color? Yes No
Are you happy with their size, shape, or length? Yes No
Do you consider them crowded or crooked? Yes No
Is there anything you would like to change about them? _____

Back Teeth: Are they tender or sore when biting? Yes No
Are they sensitive to hot or cold foods? Yes No
Do they trap food between them? Yes No
Is there anything you would like to change about them? _____

Gums: Do they hurt when brushing or flossing? Yes No
Do they ever bleed? Yes No
Do you easily develop bad breath? Yes No
Is there anything you would like to change about them? _____

Missing Teeth: Do you have any missing teeth? Yes No
Do you have a replacement for them? Yes No
Are you satisfied with the fit, bite, or appearance of your replacement? Yes No
Is there anything you would like to change about your missing teeth or replacement? _____

Medical History

Please realize that many medications that you may be using and health conditions you may have could make a significant difference in how we treat your dental needs. We ask that you assist us in maintaining our effort for optimal and safe dental care by completing the following information as thoroughly as possible. Furthermore, we genuinely care about your overall health and aim to do our part to support and enhance your well-being. Thank you.

Medications

Please list all prescribed medications as well as over-the-counter medications you are routinely taking and reason for their use.

Allergies

Please indicate any drug or material allergies and specify by name (antibiotic, narcotic pain medication, latex, etc.)

General

- Do you require antibiotic pre-medication before dental treatment? Yes No
- Have you been hospitalized in the past 2 years? Reason: _____ Yes No
- Do you smoke or use tobacco? Yes No

Cardiovascular

- High Blood Pressure
- Rheumatic Fever
- Mitral valve prolapse, Artificial heart valve
- Congenital Heart Defect
- Heart Attack – Year: _____
- Congestive Heart Failure, Angina/Chest pain
- Pace Maker

Hematologic

- Anemia or Hemophilia – Please circle
- Blood Thinner (aspirin, coumadin, plavix, etc.)
- Hepatitis – Please circle: A B C D

Pregnancy

- Currently pregnant – Weeks: _____
- Nursing
- Currently taking birth control

Endocrine

- Diabetes – Please circle: Type I Type II
- Thyroidism – Please circle: Hypo Hyper
- Adrenal Disorder
- Transplant – Organ: _____ Year: _____
- Hormone Replacement – Hormone: _____

Cancer

What type _____
 Year Diagnosed _____

Neurologic

- Frequent Headaches
 Most common time of day: _____
 Typical trigger: _____
- Stroke – Year: _____
- Epilepsy/Seizures – Trigger: _____
- Psychiatric Disorder – Type: _____
- History of Drug or Alcohol Abuse
- Bulimia or Anorexia

Pulmonary

- Tuberculosis (TB)
- Asthma
- Chronic Bronchitis, COPD, Emphysema

Genitourinary

- Kidney Failure – Dialysis days: _____
- STD – Type: _____
- HIV/AIDS

Miscellaneous

- Artificial Hip or Knee – Please circle
- Arthritis – Type: _____
- Fever Blisters/Cold Sores
- TMD
- Sjogrens Disease
- Gastric Reflux (GERD)
- Chronic Dry Mouth (Xerostomia)
- Other Conditions We Should Be Aware Of

I authorize Dr. Ryan Galligan and staff to perform radiographs (x-rays), photographs, or other routine diagnostic procedures necessary to make a thorough diagnosis of my dental needs.

I acknowledge that the information provided here is as complete as possible and to the best of my knowledge.

Patient Name

Signature (Patient/Legal Guardian)

Date