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Welcome!

So that we may provide you with the best possible care please complete all pages of the medical/dental history form.
All information is completely confidential.

Patient's Name: _____ Date: _____

Address: _____

Home Phone:_____ Cell #: _____ Work #: _____

Email: _____ Date of Birth: _____

Emergency Contact: _____ Phone #: _____

Physician Name: _____ Phone #: _____

Address: _____

Pharmacy Name: _____ Phone #: _____

Are you currently under the care of a physician ..... YES NO

If so, what is the condition being treated _____

Are you allergic or have you ever had a reaction to:

Alcohol .....YES NO	Latex .....YES NO
Aspirin .....YES NO	Narcotics .....YES NO
Codeine .....YES NO	Penicillin .....YES NO
Iodine .....YES NO	Sulfa Drugs .....YES NO
Local anesthetic .....YES NO	Other _____

Have you had any serious illness, surgeries or been hospitalized in the last 5 years?.....YES NO

If yes, what was the illness/surgery _____

Have you had any JOINT REPLACEMENT surgeries? .....YES NO

If yes, what joint(s) have been replaced? _____

Does your physician require you to pre-medicate with antibiotics for dental treatment?.....YES NO

If yes, what medication and dosage? _____

Are you taking ANY medicine(s) including non-prescription?.....YES NO

Please list medications:_____

_____

_____

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel or Boniva?.....YES NO

If yes, please list name and dosage _____

Have you ever or currently have cancer?.....YES NO

Type and treatment regimen _____

Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item.

Heart (Surgery, Disease, Attack)...	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle) ...	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S./H.I.V. Positive	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	Cold Sores/Fever Blisters	Yes	No
High/Low Blood Pressure	Yes	No	Contact lenses	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No	Liver Disease/Yellow Jaundice ..	Yes	No
Cortisone Medicine	Yes	No	Hay Fever/Allergy/Hives	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care..	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Cancer	Yes	No

Do you have or have you had any disease, condition or problem not listed?.....YES NO

If yes, please list: _____

WOMEN

Are you pregnant or think you could be pregnant? YES _____ Months NO Nursing? YES NO

Do you use birth control prescriptions? .....YES NO

Dental History

What is the reason for you visit today? _____

_____

Date of Last Dental Visit: _____ Last Dental Cleaning: _____ Last X-rays: _____

Previous Dentist Name: _____ Telephone: _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Do you have any dental problems now? YES NO (please describe) _____

_____

Do you feel nervous about having dental treatment? YES NO (please describe) _____

_____

Have you ever had an upsetting dental experience? YES NO (please describe) _____

_____

Have you ever been told to take a pre-medication prior to dental treatment? .....YES NO

Is there anything else about having dental treatment that you would like us to know? ..... YES NO

If yes please explain _____

_____

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

Please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to replace your silver fillings?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, etc.)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor and/or staff of any change in my health or medications.

Patient/Guardian Signature: _____ **Date:** _____