PATIENT INFORMATION

Name: ____ D.O.B.______________________________

Home Address: ____ Home Phone:_________________________

City ___________________________________State______Zip________ Cell Phone:___________________________

Referring Dentist:____ City:_________________________________

Your Physician: _________________________________City:____________ Physician's Phone:______________________
Very important in case we need to contact your physician for medical reasons

Date of last physical examination:______________________________ Purpose of Examination: _____________________

MEDICAL HEALTH HISTORY

History of smoking? ☐ Yes ☐ No If yes, how many per day:__________How long have you been smoking? _________ Quit Date:_________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

HEART PROBLEMS
- Chest Pain.. ☐
- High Blood Pressure....................... ☐
- Heart Murmur................................ ☐
- Angina Pectoris.............................. ☐
- Taking Heart Medication............... ☐
- Rheumatic Fever............................ ☐
- Pacemaker...................................... ☐
- Artificial Heart Valve..................... ☐
- Mitral Valve Prolapse.................... ☐
- Congenital Heart Lesions.............. ☐
- Heart Attack.................................... ☐
- Bypass.. ☐

- Stroke .... ☐
- Diabetes... ☐
- Stomach Ulcers .... ☐
- Kidney Trouble .... ☐
- Fainting Spells or Epilepsy .... ☐
- Glaucoma .... ☐

- Infectious Diseases .... ☐
- HIV Positive .... ☐
- AIDS .... ☐
- Hepatitis (A) (B) (C) .... ☐
- Liver Disease .... ☐
- Yellow Jaundice .... ☐
- Cold Sores .... ☐

BONE OR JOINT PROBLEMS
- Joint Replacement .... ☐
- Implants .... ☐
- Arthritis .... ☐
- Cortisone Medicine .... ☐
- Pain in Joints .... ☐
- Osteoporosis...................................... ☐

RESPIRATORY DISEASE
- Tuberculosis .... ☐
- Emphysema .... ☐
- Asthma .... ☐
- Sinus Problems .... ☐
- Hay Fever .... ☐

BLOOD PROBLEMS
- Easy Bruising .... ☐
- Blood Transfusion .... ☐
- Abnormal Bleeding .... ☐
- Hemophilia .... ☐
- Anemia .... ☐

- Cancer/Tumor..................................... ☐
- Chemotherapy .... ☐
- Radiation Therapy .... ☐

- Physical Limitation............................ ☐
- Hearing Impairment .... ☐
- Psychiatric Treatment .... ☐
- Depression .... ☐
- Anxiety Disorder .... ☐

- Drug Addiction .... ☐
- Alcoholism .... ☐
- Chewing Tobacco .... ☐

AN ALLERGIC REACTION TO:
- Aspirin .... ☐
- Codeine .... ☐
- Dental Anesthetic .... ☐
- Erythromycin .... ☐
- Penicillin .... ☐
- Sedatives or Sleeping Pills .... ☐
- Sulfa .... ☐
- Tetracycline .... ☐
- Other .... ☐
- List .... ☐

IF FEMALE, ARE YOU
- Taking birth control pills .... ☐
- Pregnant .... ☐
- Trying to conceive .... ☐
- Presently in menopause .... ☐
- Past menopause .... ☐

Is there anything else we should know about your medical history? ____
____

WHAT MEDICATIONS ARE YOU TAKING NOW?

Medication:________________________________Condition:____________________________________How Long?_________
Medication:________________________________Condition:____________________________________How Long?_________
Medication:________________________________Condition:____________________________________How Long?_________
Medication: _______________________________Condition:____________________________________How Long?_________

____
Date Signature of Patient, Parent or Guardian Reviewed By

____
Date Signature of Patient, Parent or Guardian Reviewed By

GETTING TO KNOW YOU

What is your estimate of your dental health? □ Good □ Fair □ Poor

What specific dental concerns do you have now? ____
____

What are your long-term goals for your teeth/gums? ____

How long since your last dental visit? __________________________What was done? _________________________
____

How many times a year do you have your teeth professionally cleaned? ____________
When was your last cleaning? ___________________________________

How many times a day do you brush your teeth? __________________________ Floss? ________________

Do you grind or clench your teeth? _________ Yes _________ No
If **yes**, do you currently or have you previously worn a night guard? ______ Yes _______ No

Have you ever been treated for Gum Disease? ______ Yes _______No
If **yes**, when ? ________________________

What was done? _______ Deep Cleaning __________ Gum surgery __________ Gum grafting

Which of the following dental services have you received?

- □ Extractions **Due to**: □ Decay/Broken down teeth □ Wisdom teeth □ Loose/Bone loss
- □ Root Canals □ Crowns/Caps
- □ Braces Start year:___________________ Completion Year:________________
- □ Implants □ Other___________________

Have you had problems or undesirable experiences with previous dental treatment? □ Yes □ No

What can we do to make you most comfortable?____

Is there anything else you would like us to be aware of?____