DENTAL HISTORY:

Primary Reason for Today's Visit:_____

Do you take premedication or antibiotics prior to dental treatment? _____

Name and Contact Information of Prior Dentist: _____

Last Dental Exam: _____ Last Dental X-Rays: _____

Times you brush per day: _____ Times you floss per day: _____

Please Check All That Apply & Explain Location or Circumstances:

Teeth:
___Sensitivity_____
___Toothache_____
__Lost, Broken Fillings, Crowns_____
__Broken, Chipped Teeth_____
___Staining_____
__Loose Teeth_____

Gums:
__Red, Swollen, Bleeding_____
__ Food Trapping Between Teeth or Under Gums_____

Jaws:
__Discomfort, Popping, Clicking_____
__Grinding, Clenching_____
__Locking_____

Lips, Tongue, Mouth:
__Blisters, Sores_____
__Sore Throat_____
___Lumps_____
__Bad Breath_____
__Dry Mouth_____

Dental History:
__Prolonged Bleeding After Extraction_____
__Radiation to Head and Neck_____
__Serious Head and Neck Injury_____
__Surgery_____
__Removable appliances_____

HEALTH HISTORY

Primary Physician:

Name: _____ Mobile: (_____)_____-_____ Email: _____

Address:

_____

Conditions Currently In Treatment:

_____

Preferred Pharmacy:

Name: _____ Mobile: (_____)_____-_____ Email: _____

Address:

_____

Please Check All That Apply:

Have you ever been hospitalized or had a major operation?
If yes, please explain: _____

Are you taking any medications, pills, or drugs?
If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux?
If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other biphosphonates?
If yes, please explain: _____

Do you use tobacco/chewing tobacco now or in the past?_____How long?____

Women:
Are you Pregnant/Trying to get pregnant? _____
Taking Oral Contraceptives?_____
Nursing?_____

Allergies:
□ Aspirin □ Penicillin □ Codeine □ Sulfa Drugs □ Acrylic
□ Metal □ Latex □ Local Anesthetics □ Other If yes, please explain:

_____

Please Check All That Apply & Explain Location or Circumstances:

___AIDS/HIV Positive _____
___Alzheimer's Disease_____
___Anaphylaxis_____
___Anemia_____
___Angina _____
___Arthritis/Gout_____
___Artificial Heart Valve_____
___Artificial Joint_____
___Asthma_____
___Blood Disorder _____
___Breathing Problem_____
___Bruise Easily_____
___Cancer_____
___Chemotherapy_____
___Chest Pains_____
___Congenital Heart Disorder _____
___Convulsions _____
___Cortisone Medicine _____
___Diabetes _____
___Drug Addiction_____
___Easily Winded_____
___Emphysema_____
___Epilepsy or Seizures _____
___Excessive Bleeding_____
___Excessive Thirst _____
___Fainting Spells/Dizziness_____
___Frequent Cough _____
___Frequent Diarrhea _____
___Frequent Headaches_____
___Genital Herpes _____
___Glaucoma_____
___Hay Fever_____
___Heart Attack/Failure _____
___Heart Murmur_____
___Heart Pace Maker _____
___Heart Trouble/Disease _____
___Hemophilia_____
___Hepatitis A_____

___Hepatitis B or C_____
___Herpes_____
___High Blood Pressure_____
___Hives or Rash_____
___Hypoglycemia_____
___Irregular Heartbeat _____
___Kidney Problems_____
___Leukemia _____
___Liver Disease _____
___Low Blood Pressure_____
___Lung Disease_____
___Mitral Valve Prolapse _____
___Pain in Joints _____
___Pancreatic Disease _____
___Psychiatric Care _____
___Radiation Treatments _____
___Recent Weight Loss _____
___Renal Dialysis _____
___Rheumatic Fever _____
___Scarlet Fever_____
___Shingles_____
___Sickle Cell Disease_____
___Sinus Trouble_____
___Stomach/Intestinal Disease_____
___Stroke_____
___Swelling of Limbs_____
___Thyroid Disease_____
___Tonsillitis_____
___Tuberculosis_____
___Tumors or Growths _____
___Ulcers_____
___Venereal Disease_____
___Yellow Jaundice_____

Have you ever had any serious illness not listed above? O Yes O No
If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or Guardian: _____ **Date:** _____
Printed Name of Patient: _____**Date of Birth:** _____