GENERAL HEALTH : ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

ALLERGIES/ALLERGIC REACTIONS ☐ ASPIRIN ☐ LOCAL ANESTHETIC ☐ BARBITURATES ☐ CODEINE

☐ IODINE ☐ LATEX ☐ PENICILLIN ☐ SULFA ☐ METAL SENSITIVITY ☐ NITROUS OXIDE ☐ OTHER _____

☐ ACID REFLUX	☐ BULIMIA	☐ HEARING PROBLEMS	☐ PHYSCHIATRIC TREATMENT
☐ ADHD	☐ CANCER/MALIGNANCY	☐ HEART ATTACK	☐ RADIATION/CHEMO
☐ AIDS/HIV	☐ CEREBRAL PALSY	☐ HEART DIEASE	☐ RESPIRATORY DIEASE
☐ ANEMIA	☐ CHEMICAL DEPENDENCY	☐ HEART MUR MUR	☐ RHEUMAIC FEVER
☐ ANOREXIA	☐ CHICKEN POX	☐ HEPATITIS	☐ SINUS PROBLEMS
☐ ANXIETY	☐ CONVULSIONS	☐ HIGH BLOOD PRESSURE	☐ STROKE
☐ ARTIFICIAL HEART VALAVE	☐ DEPRESSION	☐ KIDNEY DIEASE	☐ THYROID CONDITION
☐ ARTIFICIAL JOINTS	☐ DIABETES	☐ LIVER PROBLEMS	☐ TUBERCULOSIS
☐ ARTHRITIS	☐ DIZZINESS/FAINTING	☐ MITRAL VALVE PROLAPSE	☐ ULCERS
☐ ASTHMA	☐ EPILEPSY/SEIZURES	☐ MONONUCLEOSIS	☐ VENEREAL DISEASE
☐ AUTISM/ASPERGERS	☐ FREQUENTEAR INFECTIONS	☐ PACEMAKER	☐ OTHER –PLEASE LIST
☐ BLEEDING DISORDER	☐ FREQUENT HEADACHES	☐ OSTEOPOROSIS	

FEMALE PATIENTS: Y N Currently nursing? Y N Currently pregnant? Y N Taking birth control?

Is there anything important about your medical condition we have not asked ? ☐ Y ☐ N If yes, please describe: _____

Have you ever taken Bisphosphonate Medications? (Ex :Actonel, Boniva, Reclast, Fosamax) ☐ Yes ☐ No

Y ☐ N ☐ UNDER A PHYSICIAN'S CARE NOW?

Y ☐ N ☐ ANY HOSPITALIZATION IN THE PAST 5 YEARS? _____

Y ☐ N ☐ ANY SERIOUS ILLNESSES/SURGERIES? _____

Y ☐ N ☐ USE TOBACCO IN ANY FORM? IF YES, TYPE: _____

Y ☐ N ☐ IS PRE-MEDICATION REQUIRED BEFORE DENTAL VISITS DUE TO HEART CONDITION OR ARTIFICIAL JOINT? IF SO EXPLAIN: _____

MEDICATIONS – LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING WITH THE DOSAGE AND DIAGNOSIS

DRUG NAME	DOSAGE	REASON PRESCRIBED

PATIENT CONSENT

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

Signature _____ Date _____

RELATIONSHIP TO PATIENT ☐ ADULT PATIENT ☐ PARENT ☐ GUARDIAN ☐ OTHER

WELCOME

PATIENT INFORMATION

Todays Date: ___/___/___ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Date of Birth: ___/___/___ Sex: ☐Male ☐Female

Social Security# ___—___—___ Email Address: _____

Patient Name : _____ Referred by/Where did you see or hear about us?

Address : _____ _____

City: _____ State: _____ Zip: _____

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

Emergency Contact Name/Relationship: _____ Contact number: _____

Reason for today's visit: _____

Primary Physician: _____

Telephone #: _____

City/State: _____

Former Dentist: _____

Telephone #: _____

Date of last visit: _____ Date of last Xrays: _____

DENTAL HISTORY

Y	N		Y	N	
☐	☐	Bad breath	☐	☐	Burning sensation on tongue
☐	☐	Dry mouth	☐	☐	Mouth pain/bruising
☐	☐	Bleeding gums	☐	☐	Orthodontic treatment
☐	☐	Grinding teeth	☐	☐	Food Collection
☐	☐	Fingernail biting	☐	☐	Sensitivity to heat
☐	☐	Pain around ear	☐	☐	Jaw clicking or popping
☐	☐	Sore/growth in mouth	☐	☐	Sensitive to sweets
☐	☐	Smoking (tobacco)	☐	☐	Gums swollen/tender
☐	☐	Chewing on one side	☐	☐	periodontal treatment
☐	☐	Jaw pain	☐	☐	Sensitivity to cold
☐	☐	Sensitivity to biting	☐	☐	Lip/Cheek biting