Welcome to our office. We appreciate the confidence you place in us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

PATIENT NAME_____ DATE_____

Primary reason for this dental appointment ☐ Examination ☐ Emergency ☐ Consultation

DENTAL HISTORY **YES NO**

Do you have a Specific Dental Problem? _____ ☐ ☐
Do you have dental examinations on a routine basis? Last visit? _____ ☐ ☐
Do you think you have active decay or gum disease? _____ ☐ ☐
Do you brush and floss regularly? _____ ☐ ☐
Do your gums ever bleed? Explain _____ ☐ ☐
Are you dissatisfied with the appearance of your teeth? _____ ☐ ☐
Do you want to keep your remaining teeth? _____ ☐ ☐
Do you ever have clicking, popping, or discomfort in the jaw joint? _____ ☐ ☐
Date of last dental x-rays: PANORAMIC/FULL MOUTH_____ BITEWINGS_____

MEDICAL HISTORY

Are you under a physician's care? Explain _____ ☐ ☐
Have you been hospitalized or had a major operation? Explain _____ ☐ ☐
Do you take medication or pills for pain or discomfort (pain reliever, muscle relaxants, antidepressant)? ☐ ☐
If yes please list: _____
Prescribing doctor's name? _____

WOMEN

Are you currently pregnant? Due Date: _____ ☐ ☐
Doctor's name? _____

HAVE YOU EVER TAKEN BISPHOSPHONATE MEDICATITAKENIF YES PLEASE LIST- ☐ ☐
Actonel, Aredia, Boniva, Fosamax, Zometa, Bonefos, Ostac, Skelid, Didronel, Prolia, Denosmob, or other.

If yes please list: _____
Prescribing doctor's name? _____

ARE YOU CURRENTLY TAKING IT, OR HAVE YOU TAKEN IT IN THE PAST 24 HOURS? IF YES PLEASE LIST. ☐ ☐
Coumadin, Warfarin, Plavix, Pradaxa, Xarelto, Eliquis, NSAIDS, Celecoxib, Etodolac, Mefenamic acid, Piroxicam, Aspirin or any other medication with a side effect of increased bleeding?
If yes please list: _____
Prescribing doctor's name? _____

HAVE YOU EVER BEEN TOLD YOU REQUIRE PREMEDICATION BEFORE DENTAL TREATMENT? ☐ ☐

ARE YOU ALLERGIC, OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING?

	YES	NO		YES	NO
Local Anesthetics ("Novocaine")	☐	☐	Codeine, or other narcotics	☐	☐
Penicillin or other antibiotics	☐	☐	Latex	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐	Metal	☐	☐
Acrylic	☐	☐	Other	☐	☐

OVER

Preferred Pharmacy: _____ **Phone number:** _____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK THE APPROPRIATE BOXES.

*If yes to any of the starred conditions, please call prior to your appointment. Premedication may be required before

	YES	NO		YES	NO
Heart disease*	☐	☐	Recent Blood Transfusion	☐	☐
Heart murmur*	☐	☐	Lung Disease	☐	☐
Irregular heartbeat	☐	☐	Asthma	☐	☐
Angina/Chest pain	☐	☐	Emphysema	☐	☐
Heart Attack/Failure	☐	☐	Tuberculosis	☐	☐
Congenital Heart Disorder	☐	☐	Radiation	☐	☐
Mitral Valve Prolapse	☐	☐	Chemotherapy	☐	☐
Scarlet Fever	☐	☐	Stomach/Intestinal Disease	☐	☐
Rheumatic Fever*	☐	☐	Diabetes	☐	☐
Artificial Heart Valve*	☐	☐	Excessive Thirst	☐	☐
Heart Pacemaker*	☐	☐	Hypoglycemia	☐	☐
Heart Surgery*	☐	☐	Liver Disease	☐	☐
High Blood Pressure	☐	☐	Hepatitis A (infectious)	☐	☐
Low Blood Pressure	☐	☐	Hepatitis B or C	☐	☐
Blood Disease	☐	☐	Yellow Jaundice	☐	☐
Anemia	☐	☐	Kidney Problems	☐	☐
Excessive Bleeding	☐	☐	Renal Dialysis	☐	☐
Sickle Cell Disease	☐	☐	Thyroid Disease	☐	☐
Hemophilia	☐	☐	Parathyroid Disease	☐	☐
Cancer	☐	☐	AIDS	☐	☐
Arthritis/Gout	☐	☐	HIV Positive	☐	☐
Rheumatism	☐	☐	Venereal Disease	☐	☐
Pain in jaw Joints	☐	☐	Herpes	☐	☐
Artificial Joint*	☐	☐	Fever Blisters or Cold Sores	☐	☐
Cortisone Medicine	☐	☐	Drug Addiction	☐	☐
Stroke	☐	☐	Fainting/Dizziness	☐	☐
Epilepsy or Seizures	☐	☐	Tumors or Growths	☐	☐
Alzheimer's Disease	☐	☐	Nervous Disorders	☐	☐
Allergies	☐	☐	Sleep Apnea or Snoring	☐	☐

Have you ever had any other serious illness not checked above? Discuss: ☐ ☐

_____

_____

Please list all medications you are currently taking:

_____

_____

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

Patient/Parent Signature:_____ Date_____

Notes: _____

_____ Dentist Initial: _____