Welcome to our office!

We appreciate the confidence you place with 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 you have any questions, don't hesitate to ask.

(For the following questions, please (x) which ever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. This information is vital to allow us to provide appropriate care for you.)

Patient Name:_____ Date:_____Date of Birth:_____

Medical Information

Yes	No	
☐	☐	Are you in good health?
☐	☐	Has there been any change in your general health, or have you been under the care of a physician within the past 2 years?_____
☐	☐	Are you ***currently*** under the care of a physician? If so, what condition(s) is being treated?
		_____
		Physician Name:_____ Phone:_____ City/State:_____
☐	☐	Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, explain:
		_____
☐	☐	Are you presently using any medications or drugs? If so, what medications are you taking?
		_____
		_____
☐	☐	Do you have a history of alcohol/drug abuse? If yes, have you received treatment? ☐Yes ☐ No
☐	☐	Have you had an orthopedic joint replacement? If so, when:_____
☐	☐	Have you ever been told you needed antibiotic pre-medication for dental treatment?

Women Only	Yes	No		Yes	No		Yes	No	
	☐	☐	Are you pregnant?	☐	☐	Nursing?	☐	☐	Taking birth control pills?

Please (x) if you have or had any of the following:

☐ AIDS	☐ Anemia	☐ Asthma
☐ Cancer (chemo/radiation treatment)	☐ Diabetes	☐ Stroke
☐ Hepatitis or Liver Disease	☐ Kidney Treatment	☐ Tuberculosis
☐ Arthritis	☐ Mental Health Disorder (if yes, specify)_____	
☐ Fainting spells/seizures	☐ Respiratory Problems(specify)_____	

☐ Cardiovascular Disease (if yes, specify below)

☐ Angina	☐ Atherosclerosis	☐ Artificial Heart Valves	☐ Damaged Heart Valves
☐ Heart Attack	☐ Heart Murmur	☐ High Blood Pressure	☐ Mitral Valve Prolapse
☐ Pace Maker	☐ Rheumatic Heart Disease		

Other:_____

Allergies - Are you allergic to or have you had a reaction to:

Yes	No		Yes	No	
☐	☐	Local anesthetic (novocain)	☐	☐	Latex
☐	☐	Penicillin or other antibiotics	☐	☐	Sulfa drugs
☐	☐	Aspirin	☐	☐	Other (Specify)_____

Dental Information

Yes	No	
☐	☐	Are your teeth sensitive? (circle) cold hot sweet pressure
☐	☐	Do you have frequent bad breath or unpleasant taste in your mouth?
☐	☐	Do you utilize Dental Floss? If yes, how often?_____times a week
☐	☐	Do your gums bleed when you brush?
☐	☐	Have you had any periodontal (gum) treatments?
☐	☐	Do you have dry mouth?
☐	☐	Do you experience frequent cold sores or canker sores on your lips/mouth/tongue?
☐	☐	Do you have frequent (circle) headaches, earaches or neck pains?
☐	☐	Have you had/have an eating disorder? If yes, explain:_____
☐	☐	Have you ever had orthodontic treatment? If yes, when_____ where_____
☐	☐	Do you use tobacco? Type_____ How much?_____ *Are you interested in stopping? Very Somewhat Not interested*
☐	☐	Do you wear removable dental appliances (circle) denture partial night guard *If yes, date they were made(how old are they)?*_____

a) Have you ever had a serious/difficult problem associated with any previous dental treatment? If so, explain:_____

_____

b) Are you currently experiencing a dental problem? If so, explain: _____

_____

c) Date of your last dental exam?_____ What was done at that time?_____

d) Date of your last dental cleaning?_____

e) How do you feel about the appearance of your teeth (do you like your smile)?_____

_____

Patient Signature:_____ **Clinician Signature:_____**

Health History Updates:

Date	Comments	Initials

Blood Pressure: _____ _____ _____ _____ _____ _____