**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 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 on a regular basis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 🞎

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 TAKIN BISPHOSPHANATE MEDICATIONS? IF 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, OR HAVE YOU TAKEN 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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ P**hone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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 Pace Maker\* 🞎 🞎 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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*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:\_\_\_\_\_\_\_\_\_\_\_\_\_