

DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHDATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIALSECURITY#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OCCUPATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DENTAL INS PROVIDER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPOUSE/PARENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/SPOUSE EMPLOYMENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN CASE OF EMERGENCY,CONTACT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU UNDER A DOCTORS CARE? Y or N DOCTORS NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YOUR CURRENT MEDICATIONS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATIONS?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU TAKE ANY BLOOD THINNERS?** YesorNo **WARFARIN COUMADIN PLAVIX PRADAX A AGGRENOX EFFIENT XARELTO ELIQUIS**

**ANY OSTEOPOROSIS MEDICATION?** Yesor No **FOSAMAX DIDRONEL BONIVA AREDIA ZOMETA RECLAST OTHER**

**DO YOU HAVE ANY ARTIFICAL HIPS, KNEES, OR HEART VALVES?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**YEARPLACED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU ALLERGIC TO THE FOLLOWING? **LATEX** **PENICILLIN** **KEFLEX CECLOR** **SULFA** **OTHER(CIRCLE)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

HAVE YOU EVER HAD SURGERY AND WHY?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU USE ANY FORM OF TOBACCO AND WOULD YOU LIKE HELP QUITTING?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE ANY JAW JOINT PAIN?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DO YOU GRIND YOUR TEETH?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE A BITE GUARD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HAVE YOU HAD BRACES?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE ANY PAIN IN YOUR HEAD/NECK/TMJ AREA?\_\_\_\_\_\_\_\_\_\_\_WHEN?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOW OFTEN?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHEN WAS YOUR LAST CLEANING?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WHO WASYOUR LAST DENTIST?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU EVER BEEN TREATED FOR GUM DISEASE (PERIODONTAL DISEASE)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INTERESTED IN COSMETIC DENTISTRY? **TOOTH** **WHITENING/PORCELAIN** **VENERRS/MINOR** **TOOTH** **MOVEMENT/PORCELAIN** **CROWNS**

ARE YOU HAVING ANY DENTAL PAIN TODAY?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WHERE?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW LONG HAVE YOU HAD THIS PAIN?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RATE THIS PAIN ON 1--‐10 SCALE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HAVE YOU TAKEN PAIN RELIEVERS FOR THIS PAIN?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TODAYS**

**DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 Do you have or have you had any disease, or condition not listed? Yes or No

 If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Indicate which of the following your have had, or have at present. Circle “Yes” or “No” for each item.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Heart Disease or attack | Yes | No | Artificial joints (Hip, knees, etc) | Yes | No | Hypatitis B | Yes | No |
| Heart Failure | Yes | No | Stroke | Yes | No | Hepatitis C | Yes | No |
| Angina Pectoris | Yes | No | Kidney Stone | Yes | No | Arteiosclerosis (hardening of arteries) | Yes | No |
| Congenital Heart Disease | Yes | No | Venereal Disease | Yes | No | Ulcers | Yes | No |
| Diabetes | Yes | No | Heart Murmur | Yes | No | AIDS | Yes | No |
| HIV positive | Yes | No | Glaucoma | Yes | No | Blood transfusion | Yes | No |
| High Blood Pressure | Yes | No | Cortisone Medication | Yes | No | Cold Sores/Herpes | Yes | No |
| Mitral Valve Prolapse | Yes | No | Cosmetic Surgery | Yes | No | Artificial heart valve | Yes | No |
| Emphysema | Yes | No | Anemia | Yes | No | Heart Pacemaker | Yes | No |
| Chronic Cough | Yes | No | Heart surgery | Yes | No | Sickle cell disease | Yes | No |
| Tuberculosis | Yes | No | Bruise easily | Yes | No | Asthma | Yes | No |
| Liver Disease | Yes | No | Rheumatic fever | Yes | No | Yellow Jaundice | Yes | No |
| Arthritis | Yes | No | Epilepsy or Seizures | Yes | No | Rheumatism | Yes | No |
| Allergies or Hives | Yes | No | Nervousness | Yes | No | Fainting or Dizzy spells | Yes | No |
| Sinus Trouble | Yes | No | Radiation Therapy | Yes | No | Chemotherapy | Yes | No |
| Pain in Jaw joints  | Yes | No | Thyroid Problems | Yes | No | Drug Addiction | Yes | No |
| Hay Fever | Yes | No | Hypatitis A | Yes | No | Psychiatric Treatment | Yes | No |

 For women only:
 Are you pregnant? Yes or No If yes, what month? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Are you nursing? Yes or No Are you taking birth control pills? Yes or No

 **I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.**

 Patient Signaure:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dentist’s signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Review Date** | **Change’s in Health Status** | **Patient’s signature** | **Dentist’s signature** |
|  |  |  |  |
|  |  |  |  |