Thank you **for filling out this form completely.**

It will enable our office to be more effective in meeting your needs.

If you have any questions at any time, please ask us. We will be happy to help.

Name: _____

Today's Date: _____/_____/_____ Birthdate: _____/_____/_____ Home Phone Number: (____)_____

Dental History

Why have you come to the dentist today? _____

_____

_____

Are you currently in pain? ☐ Yes ☐ No

Have you experienced problems associated with any previous dental work? ☐ Yes ☐ No

Do you have frequent headaches? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss? ☐ Yes ☐ No

If yes, what? _____

Do you require antibiotics before dental work? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Does food get caught between your teeth? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you still have your wisdom teeth? ☐ Yes ☐ No

Do you have any loose teeth? ☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No

If yes, why? _____

Are you happy with the way your smile looks?

☐ Yes ☐ No

If not, what would you change? _____

_____

_____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Address: _____

_____

City State Zip

Phone #: (____)_____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No

Have you ever taken Fosamax or any other bisphosphonate?

If yes, when? _____ ☐ Yes ☐ No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs/substances that cause allergic reactions:

_____

_____

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week #: _____

Are you nursing? ☐ Yes ☐ No

Are you taking any of the following?

Acetaminophen	☐ Yes ☐ No	Blood Pressure Medication	☐ Yes ☐ No	Nitroglycerin	☐ Yes ☐ No
Antibiotics	☐ Yes ☐ No	Cold Remedies	☐ Yes ☐ No	Recreational Drugs	☐ Yes ☐ No
Antihistamines	☐ Yes ☐ No	Digitalis / Heart Medication	☐ Yes ☐ No	Steroids / Cortisone	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No	Herbal Supplements	☐ Yes ☐ No	Thyroid Medicine	☐ Yes ☐ No
Blood Thinners	☐ Yes ☐ No	Insulin / Diabetes Drugs	☐ Yes ☐ No	Tranquilizers	☐ Yes ☐ No

Are you taking any prescription/over-the-counter or herbal supplement drugs not listed above? ☐ Yes ☐ No

If yes, please list each one: _____

CONTINUED ON BACK

Medical History

(CONTINUED)

Have you experienced the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Fainting Spells	Y	N	Pacemaker
Y	N	Alcohol Abuse	Y	N	Fever Blisters	Y	N	Persistent Cough
Y	N	Anemia	Y	N	Frequent Headaches	Y	N	Psychiatric Problems
Y	N	Arthritis	Y	N	Glaucoma	Y	N	Radiation Treatment
Y	N	Artificial Bones / Joints	Y	N	Hay Fever	Y	N	Rheumatic Fever
Y	N	Artificial Valves	Y	N	Heart Attack	Y	N	Scarlet Fever
Y	N	Asthma	Y	N	Heart Murmur	Y	N	Seizures
Y	N	Blood Transfusion	Y	N	Heart Surgery	Y	N	Severe Headaches
Y	N	Cancer	Y	N	Hemophilia	Y	N	Shingles
Y	N	Chemotherapy	Y	N	Hepatitis	Y	N	Sickle Cell Disease
Y	N	Chicken Pox	Y	N	Herpes / Fever Blisters	Y	N	Sinus Problems
Y	N	Colitis	Y	N	High Blood Pressure	Y	N	Steroid Therapy
Y	N	Congenital Heart Defect	Y	N	HIV+ / AIDS	Y	N	Stroke
Y	N	Diabetes	Y	N	Hospitalized for Any Reason	Y	N	Thyroid Problems
Y	N	Difficulty Breathing	Y	N	Kidney Problems	Y	N	Tonsillitis
Y	N	Drug Abuse	Y	N	Liver Disease	Y	N	Tuberculosis (TB)
Y	N	Emphysema	Y	N	Low Blood Pressure	Y	N	Ulcers
Y	N	Epilepsy	Y	N	Mitral Valve Prolapse	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have experienced: _____

_____

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____
Signature Date

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.
My method of payment will be _____

_____ _____
Signature Date

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions.

Patient Comments:

_____ _____
Patient Signature Date

_____ _____
Doctor Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions.

Patient Comments:

_____ _____
Patient Signature Date

_____ _____
Doctor Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions.

Patient Comments:

_____ _____
Patient Signature Date

_____ _____
Doctor Signature Date