⃝ Mr. ⃝ Mrs. ⃝ Ms. ⃝ Dr. First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I.\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_

Home (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How would you like your appointments confirmed?

⃝ Phone Call ⃝ Text ⃝ Email (check all that apply)

Whom may we thank for referring you to our practice?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a physician? ⃝ Yes ⃝ No Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ⃝ Yes ⃝ No

If so, please list **all**, including vitamins, natural or homeopathic products:

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

Are you taking any blood thinners? (Pradaxa, Coumadin, Plavix etc.) ⃝ Yes ⃝ No

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

Have you had an orthopedic total joint (hip, knee, elbow) replacement? ⃝ Yes ⃝ No

Were there any complications? ⃝ Yes ⃝ No

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Procedure Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? ⃝ Yes ⃝ No

If yes, what do you pre-medicate with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women Only**: Are you pregnant? ⃝ Yes ⃝ No Nursing? ⃝ Yes ⃝ No Taking birth control or hormonal replacement? ⃝ Yes ⃝ No

**Dental Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Do your gums bleed when you brush or floss? | ⃝ Yes ⃝ No | Do you have earaches or neck pains? | ⃝ Yes ⃝ No |
| Are your teeth sensitive to cold, hot, sweets or pressure? | ⃝ Yes ⃝ No | So you have any clicking, popping or discomfort in the jaw? | ⃝ Yes ⃝ No |
| Does food catch between your teeth? | ⃝ Yes ⃝ No | Do you brux or grind your teeth? | ⃝ Yes ⃝ No |
| Is your mouth dry? | ⃝ Yes ⃝ No | Do you have sores or ulcers in your mouth? | ⃝ Yes ⃝ No |
| Have you had any periodontal (gum) treatment? | ⃝ Yes ⃝ No | Do you wear dentures or partials? | ⃝ Yes ⃝ No |
| Have you ever had orthodontic (braces) treatment? | ⃝ Yes ⃝ No | Do you participate in active recreational activities? | ⃝ Yes ⃝ No |
| Have you had any problems associated with previous dental treatment? | ⃝ Yes ⃝ No | Have you ever had a serious injury to your head or mouth? | ⃝ Yes ⃝ No |
| Is your home water supply fluoridated? | ⃝ Yes ⃝ No | Date of your last dental exam: | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you drink bottled or filtered water? | ⃝ Yes ⃝ No | What was done at that time? | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you experiencing dental pain or discomfort? | ⃝ Yes ⃝ No | Date of your last dental x-rays: | \_\_\_\_\_\_\_\_\_\_\_\_ |

What is the reason for your dental visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you feel about your smile?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When was your last dental visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Dental Cleaning? \_\_\_\_\_**

**Medical History**

**Allergies – Are you allergic to or have you had a reaction to:**

|  |  |  |  |
| --- | --- | --- | --- |
| Local anesthetics | ⃝ Yes ⃝ No | Metals | ⃝ Yes ⃝ No |
| Aspirin | ⃝ Yes ⃝ No | Latex (rubber) | ⃝ Yes ⃝ No |
| Penicillin or other antibiotics | ⃝ Yes ⃝ No | Iodine | ⃝ Yes ⃝ No |
| Barbiturates, sedatives or sleeping pills | ⃝ Yes ⃝ No | Hay Fever/Seasonal | ⃝ Yes ⃝ No |
| Sulfa drugs | ⃝ Yes ⃝ No | Botox (Botulinum toxin)/Juvederm | ⃝ Yes ⃝ No |
| Codeine or other narcotics | ⃝ Yes ⃝ No | Tetracycline | ⃝ Yes ⃝ No |
| Erythromycin | ⃝ Yes ⃝ No | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ⃝ Yes ⃝ No |

Have you ever had Botox or Juvederm? ⃝ Yes ⃝ No Are you interested in learning more about Botox or Juvederm? ⃝ Yes ⃝ No

**Indicate which of the following you have had, or have at present:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Cardiovascular disease | ⃝ Yes ⃝ No | AIDS or HIV infection | ⃝ Yes ⃝ No | Thyroid problem | ⃝ Yes ⃝ No |
| Angina | ⃝ Yes ⃝ No | Arthritis | ⃝ Yes ⃝ No | Stroke | ⃝ Yes ⃝ No |
| Arteriosclerosis | ⃝ Yes ⃝ No | Autoimmune disease | ⃝ Yes ⃝ No | Glaucoma | ⃝ Yes ⃝ No |
| Congestive heart failure | ⃝ Yes ⃝ No | Rheumatoid arthritis | ⃝ Yes ⃝ No | Hepatitis, jaundice or liver disease | ⃝ Yes ⃝ No |
| Damaged heart valves | ⃝ Yes ⃝ No | Lupus  | ⃝ Yes ⃝ No | Epilepsy | ⃝ Yes ⃝ No |
| Heart attack | ⃝ Yes ⃝ No | Asthma | ⃝ Yes ⃝ No | Fainting spells or seizures | ⃝ Yes ⃝ No |
| Heart murmur | ⃝ Yes ⃝ No | Lung disease | ⃝ Yes ⃝ No | Neurological disorders | ⃝ Yes ⃝ No |
| Low blood pressure | ⃝ Yes ⃝ No | Emphysema | ⃝ Yes ⃝ No |  If yes, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| High blood pressure | ⃝ Yes ⃝ No | Sinus trouble | ⃝ Yes ⃝ No | Sleep disorder | ⃝ Yes ⃝ No |
| Artificial (prosthetic) heart valve | ⃝ Yes ⃝ No | Tuberculosis | ⃝ Yes ⃝ No | Mental health disorder If yes, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ⃝ Yes ⃝ No |
| Previous infective endocarditis | ⃝ Yes ⃝ No | Cancer/Chemotherapy/ Radiation treatment | ⃝ Yes ⃝ No | Reflux/persistent heartburn | ⃝ Yes ⃝ No |
| Congenial heart disease (CHD) | ⃝ Yes ⃝ No | Tumor(s) | ⃝ Yes ⃝ No | Recurrent infections | ⃝ Yes ⃝ No |
| Mitral valve prolapse | ⃝ Yes ⃝ No | Chest pain  | ⃝ Yes ⃝ No | Contagious diseases | ⃝ Yes ⃝ No |
| Pacemaker | ⃝ Yes ⃝ No | Diabetes Type 1 or 2 | ⃝ Yes ⃝ No | Kidney Problems | ⃝ Yes ⃝ No |
| Rheumatic fever | ⃝ Yes ⃝ No | Excessive urination | ⃝ Yes ⃝ No | Night Sweats | ⃝ Yes ⃝ No |
| Rheumatic heart disease | ⃝ Yes ⃝ No | Eating disorder | ⃝ Yes ⃝ No | Osteoporosis | ⃝ Yes ⃝ No |
| Abnormal bleeding | ⃝ Yes ⃝ No | Malnutrition | ⃝ Yes ⃝ No | Persistent swollen glands | ⃝ Yes ⃝ No |
| Anemia | ⃝ Yes ⃝ No | Gastrointestinal disease | ⃝ Yes ⃝ No |  in neck |  |
| Blood transfusion  | ⃝ Yes ⃝ No | Pneumonia/Bronchitis | ⃝ Yes ⃝ No | Severe headaches or migraines | ⃝ Yes ⃝ No |
| Hemophilia | ⃝ Yes ⃝ No | Ulcers | ⃝ Yes ⃝ No | Sexually transmitted disease | ⃝ Yes ⃝ No |
| Sleep Apnea or Insomnia | ⃝ Yes ⃝ No | Fibromyalgia | ⃝ Yes ⃝ No | Shingles | ⃝ Yes ⃝ No |
| Bruise or bleed easily | ⃝ Yes ⃝ No | Organ Transplant | ⃝ Yes ⃝ No | Scarlet Fever | ⃝ Yes ⃝ No |
| Blood disease/disorder | ⃝ Yes ⃝ No | Swelling in ankles | ⃝ Yes ⃝ No | Sickle Cell disease | ⃝ Yes ⃝ No |

Do you have any disease, condition or problem not listed above that you think I should know about? ⃝ Yes ⃝ No

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

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions; if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.*

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_