Dental History

Why have you come to the dentist today?_____

Do your Gums bleed when you brush? **Yes / No**

Have you had periodontal disease/surgery? **Yes / No**

Do you currently have tooth/mouth pain? **Yes / No**

Do you still have wisdom teeth? **Yes / No**

Do you require antibiotics before treatment? **Yes / No**

Are you happy with the way your smile looks? **Yes / No**

If not, what would you change?_____

_____

Date of your last dental exam: _____

Your current dental health is: **Good / Fair / Poor**

Medical History

Your current physical health is: **Good / Fair / Poor**

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

Please explain:_____

_____

Do you have a personal physician? **Yes / No**

Physician's Name _____

Address _____

Phone (_____)_____

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

Ever taken Fosamax or other bisphosphonate? **Yes / No**

Please mark "Yes" or "No" to indicate if you have any of the following:

Y N	Abnormal Bleeding	Y N	Headaches	Y N	Cardiovascular Disease
Y N	Alcohol or Drug Dependency	Y N	Hemophilia		(✓ **all that apply**)
Y N	Anemia	Y N	Hepatitis	☐	Angina
Y N	Arthritis	Y N	Liver Disease	☐	Artificial Heart Valve
Y N	Asthma	Y N	HIV+/AIDS	☐	High Blood Pressure
Y N	Artificial Bones or Joints	Y N	Kidney Problems	☐	Congenital Heart Defect
Y N	Blood Transfusions	Y N	Lupus	☐	Congestive Heart Failure
Y N	Cancer/Chemotherapy/Radiation	Y N	Neurological Disorder	☐	Coronary Artery Disease
Y N	Diabetes	Y N	Stroke	☐	Damaged Heart Valve
Y N	Difficulty Breathing	Y N	Sexually Transmitted Disease	☐	Heart Attack
Y N	Emphysema	Y N	Sinus Trouble	☐	Heart Murmur
Y N	Epilepsy	Y N	Thyroid Problems	☐	Mitral Valve Prolapse
Y N	Fainting Spells or Seizures	Y N	Tuberculosis (TB)	☐	Pacemaker
Y N	Gastrointestinal Disease	Y N	Ulcers	☐	Rheumatic Fever
				☐	Rheumatic Heart Disease

FOR WOMEN: Are you taking birth control pills? **Yes / No** **Are you pregnant?** **Yes / No**

Please list any medications you are currently taking:_____

_____

Are you allergic to any of the following:

Y N Aspirin Y N Dental Anesthetics Y N Antibiotics Y N Codeine Y N Latex

Please list any other allergies:_____

Any other condition not listed that we should know about?_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment for services rendered, any deductible, and co-payment that my insurance does not cover. I authorizes the release of my personal information should a third party collection service become necessary.

Signature_____Date_____

Please review Dental Material Fact Sheet and **initial here**:_____