DENTAL HISTORY:

REASON FOR VISIT: LAST DENTAL VISIT: LAST X-RAYS:

FORMER DENTIST: PHONE:

Are you currently in pain?

Do you require antibiotics for dental treatment?

Have you ever had periodontal disease?

Do you have loose teeth or broken fillings?

Would you like fresher breath?

Do your gums ever bleed?

Do you floss?

Do you brush?

Are you happy with your smile?

Would you like whiter teeth?

Are your teeth sensitive?

MEDICAL HISTORY:

PHYSICIAN'S NAME: PHONE:

CURRENT PHYSICAL HEALTH IS:

Are you Currently Under a Physician's care? Reason:

Have you had any serious illnesses or operations? Dates:

WOMEN: Are you pregnant? # of weeks: Are you nursing?

Are you taking birth control pills?

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING: (IF CONDITION NOT LISTED, PLEASE ADVISE STAFF)

ABNORMAL BLEEDING
AIDS
ALCOHOL/DRUG ABUSE
ANEMIA
ARTHRITIS, RHEUMATISM
ARTIFICIAL HEART VALVE
ARTIFICIAL JOINTS
ASTHMA
BACK PROBLEMS
BLOOD TRANSFUSIONS
BLOOD DISEASE
CANCER
CHRONIC HEART FAILURE
CIRCULATORY PROBLEMS
COLITIS
COPD
CORTISONE TREATMENT
CONGENITAL HEART DEFECTS
COUGH, PERSISTANT
DIABETES
DIFFICULTY BREATHING
EMPHYSEMMA
EPILEPSY
FAINTING
HEADACHES/MIGRAINES
GLAUCOMA
HEART ATTACK
HEART MURMUR
HEART PROBLEMS
HEMOPHELIA
HEPATITIS - TYPE ( )
HERPES/FEVER BLISTERS
HIGH BLOOD PRESSURE
HIV POSITIVE
JAW PAIN
KIDNEY DISEASE
LIVER DISEASE
FAMILY HISTORY OF ORAL CANCER
LOW BLOOD PRESSURE
MITRAL VALVE PROLAPSE
NERVOUS PROBLEMS
PACEMAKER
PSYCHIATRIC CARE
RADIATION TREATMENT
RESPIRATORY DISEASE
RHEUMATIC/SCARLET FEVER
SHORTNESS OF BREATH
SKIN RASH
STROKE
SICKLE CELL ANEMIA
SWELLING OF FEET/ANKLES
SHINGLES
SINUS PROBLEMS
THYROID PROBLEMS
TUBERCULOSIS
TUMERS/GROWTHS ON HEAD
DO YOU SMOKE/USE TOBACCO

Please list any other condition not listed above:

Medications: **Allergies:**

I understand that the information that I have given is correct to the best of my knowledge. I also 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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

SIGNATURE: DATE: