MEDICAL INFORMATION

PATIENT'S NAME _________________________________ DATE OF BIRTH _________ AGE ____ SEX____

It is important that we know your medical and dental history. Many things have a direct bearing on your dental health. We will review the questionnaire and discuss it with you. This information is strictly confidential.

Previous Dentist ____ Date Last Visit ________________

What prompted you to seek dental treatment or care at this time?

Yes	No	
☐	☐	Have you experienced an unusual reaction to dental anesthetic?
☐	☐	Have you ever received radiation treatment in the head or neck?
☐	☐	Do you have a pacemaker?
☐	☐	Do you have a history of sinus trouble?
☐	☐	Have you experienced slow healing sores in or about your mouth?
☐	☐	Do you have difficulty chewing your food?
☐	☐	Do your gums bleed easily?
☐	☐	Does food catch between your teeth?
☐	☐	Have you experienced difficulty opening or closing your mouth?
☐	☐	Are you dissatisfied with the appearance of your teeth?
☐	☐	Are you concerned about receiving dental treatment?
☐	☐	Do you have a history of nervousness, fainting, or dizziness?

Please list tobacco products you have used, amount per day, and for how long. ___________________________

Patient's Physician(s)____ Last Physical Exam________________
How is your general health? ☐ Good ☐ Fair ☐ Poor

Yes	No		Yes	No		Yes	No	
☐	☐	Pregnant	☐	☐	Cancer	☐	☐	Hepatitis
☐	☐	Pacemaker	☐	☐	Asthma	☐	☐	HIV / AIDS
☐	☐	Diabetic	☐	☐	Anemia	☐	☐	Venereal Disease
☐	☐	Kidney Trouble	☐	☐	Ulcer	☐	☐	Tuberculosis
☐	☐	Heart Trouble	☐	☐	Prolonged Bleeding	☐	☐	Epilepsy
☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐	Other ________________

Yes	No	
☐	☐	Joint Replacement(s): Hip, knee, other (date) _________
☐	☐	Stints, Rods, or prosthetic device placed within last 6 months
☐	☐	Artificial heart valve
☐	☐	Organ Transplant
☐	☐	Kidney dialysis
☐	☐	History of Rheumatic Fever
☐	☐	Physician Requests PREMED with dental cleanings and other treatment.

ALLERGIES – Please list all allergies, including LATEX, PENICILLIN, or other medications

☐ No Allergies

MEDICATIONS – Please list all medications, including BLOOD THINNERS, FOSAMAX, over the counter medications (i.e. aspirin), and herbals.

X____

Patient Signature Date

GENERAL INFORMATION

Patient's Name________________________________Date of Birth ____/____/

Mailing Address

City___________________________State______________Zip

Home Phone________________________SS#

Employer___________________________Work Phone

Cell#______________________Cell Phone Carrier
E-Mail

APPOINTMENT REMINDER PREFERENCE

TXT MSG ☐ Leave A Voice MSG ☐ E-Mail ☐

PERSON TO CONTACT IN CASE OF EMERGENCY:______________________

Address

Phone_________________________Relationship To Patient____________________

PERSON RESPONSIBLE FOR ACCOUNT

Address & Phone (if different from above)
Employer

Dental Insurance

Subscriber Name_________________________Date of Birth _____/_____/

SS# / ID________________________________Group #

PLEASE PRESENT DENTAL INSURANCE CARD AT THE FRONT DESK.