)ATE_____NAME_____CELL_____

:MAIL_____ BIRTHDATE_____ SOCIALSECURITY#_____

\DDRESS_____

:MPLOYER_____OCCUPATION_____DENTAL INS PROVIDER_____

'POUSE/PARENT NAME_____ Parent/SPOUSE EMPLOYMENT_____

\ CASE OF EMERGENCY,CONTACT_____PHONE_____

\RE YOU UNDER A DOCTORS CARE? Y or N DOCTORS NAME_____

'OUR CURRENT MEDICATIONS_____

\RE YOU ALLERGIC TO ANY MEDICATIONS?_____

)O YOU TAKE ANY BLOOD THINNERS? Yes or No **WARFARIN COUMADIN PLAVIX PRADAX A AGGRENOX EFFIENT XARELTO ELIQUIS**

\NY OSTEOPOROSIS MEDICATION? Yes or No **FOSAMAX DIDRONEL BONIVA AREDIA ZOMETA RECLAST OTHER**

)O YOU HAVE ANY ARTIFICAL HIPS, KNEES, OR HEART VALVES?_____YEAR PLACED_____

\RE YOU ALLERGIC TO THE FOLLOWING? **LATEX PENICILLIN KEFLEX CECLOR SULFA OTHER(CIRCLE)**_____

HAVE YOU EVER HAD SURGERY AND WHY?_____

)O YOU USE ANY FORM OF TOBACCO AND WOULD YOU LIKE HELP QUITTING?_____

)O YOU HAVE ANY JAW JOINT PAIN?_____DO YOU GRIND YOUR TEETH?_____

)O YOU HAVE A BITE GUARD_____HAVE YOU HAD BRACES?_____

)O YOU HAVE ANY PAIN IN YOUR HEAD/NECK/TMJ AREA?_____WHEN?_____HOW OFTEN?_____

WHEN WAS YOUR LAST CLEANING?_____WHO WASYOUR LAST DENTIST?_____

HAVE YOU EVER BEEN TREATED FOR GUM DISEASE (PERIODONTAL DISEASE)?_____

NTERESTED IN COSMETIC DENTISTRY? **TOOTH WHITENING/PORCELAIN VENERRS/MINOR TOOTH MOVEMENT/PORCELAIN CROWNS**

\RE YOU HAVING ANY DENTAL PAIN TODAY?_____WHERE?_____

HOW LONG HAVE YOU HAD THIS PAIN?_____

!ATE THIS PAIN ON 1---10 SCALE_____HAVE YOU TAKEN PAIN RELIEVERS FOR THIS PAIN?_____

'ODAYS

)ATE:_____*SIGNATURE*_____

Do you have or have you had any disease, or condition not listed? Yes or No

If yes, please list: _____

Indicate which of the following your have had, or have at present. Circle “Yes” or “No” for each item.

Heart Disease or attack	Yes	No	Artificial joints (Hip, knees, etc)	Yes	No	Hypatitis B	Yes	No
Heart Failure	Yes	No	Stroke	Yes	No	Hepatitis C	Yes	No
Angina Pectoris	Yes	No	Kidney Stone	Yes	No	Arteiosclerosis (hardening of arteries)	Yes	No
Congenital Heart Disease	Yes	No	Venereal Disease	Yes	No	Ulcers	Yes	No
Diabetes	Yes	No	Heart Murmur	Yes	No	AIDS	Yes	No
HIV positive	Yes	No	Glaucoma	Yes	No	Blood transfusion	Yes	No
High Blood Pressure	Yes	No	Cortisone Medication	Yes	No	Cold Sores/Herpes	Yes	No
Mitral Valve Prolapse	Yes	No	Cosmetic Surgery	Yes	No	Artificial heart valve	Yes	No
Emphysema	Yes	No	Anemia	Yes	No	Heart Pacemaker	Yes	No
Chronic Cough	Yes	No	Heart surgery	Yes	No	Sickle cell disease	Yes	No
Tuberculosis	Yes	No	Bruise easily	Yes	No	Asthma	Yes	No
Liver Disease	Yes	No	Rheumatic fever	Yes	No	Yellow Jaundice	Yes	No
Arthritis	Yes	No	Epilepsy or Seizures	Yes	No	Rheumatism	Yes	No
Allergies or Hives	Yes	No	Nervousness	Yes	No	Fainting or Dizzy spells	Yes	No
Sinus Trouble	Yes	No	Radiation Therapy	Yes	No	Chemotherapy	Yes	No
Pain in Jaw joints	Yes	No	Thyroid Problems	Yes	No	Drug Addiction	Yes	No
Hay Fever	Yes	No	Hypatitis A	Yes	No	Psychiatric Treatment	Yes	No

For women only:
Are you pregnant? Yes or No If yes, what month? _____
Are you nursing? Yes or No Are you taking birth control pills? Yes or No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient Signaure:_____ Date: _____

Dentist’s signature:_____ Date: _____

Review Date	**Change’s in Health Status**	**Patient’s signature**	**Dentist’s signature**