Health Information

We take your oral health very seriously. But before we start your treatment, we need some brief information on your medical history which may affect your treatment. All information is confidential.

Patients Name:_____Date of Birth:_____ Last Physical Date:_____

Physicians Name & Phone #:_____Reason for today's visit?_____

Work Related Injury? (circle) **Yes No** Have you been under the care of a physician? (circle) **Yes No**

Have you ever been hospitalized? (circle) **Yes No** Height:_____ Weight:_____

Date of last dental visit:_____Date of last dental x-rays:_____Date of last cleaning_____

Have you ever been treated for periodontal (gum) disease? (circle) **Yes No**

Ever had Novocaine or other local anesthetic? (circle) **Yes No**

Are you interested in tooth whitening? (circle) **Yes No**

If wearing dentures, age of dentures:_____Are you interested in new dentures? (circle) **Yes No**

Are you taking or have taken Oral Bisphosphonates?(eg. FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates, (eg. ZOMETA, AREDIA) (circle) **Yes No** Taken for how long?_____

Have you taken antibiotics prior to dental procedures in the past? (circle) **Yes No**

Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle) **Yes No**

Are you allergic to any medications or substances? Please circle below:_____

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Milk Other_____

List any medications you are taking including non-prescription drugs and herbals/vitamins:

1._____2._____3._____4._____

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Thyroid Disease			Alcoholism		
Heart Murmur			Allergies/Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Fainting or Dizzy Spells			Mouth Sores/Growths		
Diabetes			Teeth/Grinding/Clenching			Pace Maker/Heart Surgery			Aspirin/Anticoagulant Therapy		
Venereal Disease			Arthritis			Pain in your jaw (TMJ)			Ulcers or Stomach Problems		
High Blood Pressure			HIV Positive/AIDS			Latex Allergy			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Cancer (Type:)		
Any type of transplant			Heart Problem( )			Excessive Bleeding			Other Disease or Illness:		
Drug Addiction			Dialysis			Stroke					
Hepatitis (Type:)			Chemotherapy			Lung Disease					
Liver Disease			Radiation Treatment			Breathing Problems					
Kidney Disease			Use of Tobacco Products			Tuberculosis (TB)					

Women patients only:	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated Delivery Date: / /			Are you taking any birth control prescriptions?		

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient Signature_____Date_____

Patient Signature_____Date_____ **6 MONTH UPDATE**