Patient Name:_________________________________ Who Referred You ?____

DENTAL INFORMATION:

Purpose of Visit (***IF 1ST TIME PATIENT***) __________________How do you feel about your teeth/smile? _________
What would you change? _________________

When visiting the dentist are you: Fearless_____Somewhat nervous_____Scared______ Need Nitrous? ______
Bad experience in the past? ____________________

Last dental visit: ___________ Last dental cleaning___________
How often were your cleanings? Every: ____3mo____4mo____6mo Last x-rays________________

Do you have sensitive teeth ____ loose dentures ____loose caps/crowns ____bleeding gums ____ clicking jaw ___jaw joint pain ___ sinus problems ___ headaches

Do you have any snoring or sleep related breathing problems? ____
Have you ever taken Fosamax, Boniva, Actonel or other medication containing bisphosphonates? _______________

HEALTH HISTORY:

YES/NO		YES/NO		YES/NO		YES/NO	
	CARDIOVASCULAR		**LUNGS**		**OTHER**		
___/___	Mitral Valve Prolapse	___/___	Asthma	___/___	Cosmetic Surgery	___/___	Ulcers
___/___	Angina	___/___	Emphysema	___/___	Diabetes	___/___	Cold Sores
___/___	Arrhythmia	___/___	Tuberculosis	___/___	Adrenal Gland Problems	___/___	Venereal Disease
___/___	Heart Attack	___/___	Cough	___/___	Kidney Disease	___/___	Bruise Easily
___/___	Heart Murmur		**LIVER**	___/___	Thyroid Disease	___/___	Psychiatric
___/___	Heart Failure	___/___	Hepatitis _A_B_C	___/___	Radiation/Cobalt Treatment	___/___	Fainting
___/___	Congenital Heart Lesions	___/___	Cirrhosis	___/___	Chemotherapy	___/___	Cancer
___/___	Artificial Heart Valve(s)	___/___	Yellow Jaundice	___/___	Osteoporosis	___/___	Allergies
___/___	Heart Pacemaker		**BLOOD**	___/___	Arthritis	___/___	Scarlet Fever
___/___	Heart Surgery	___/___	Anemia	___/___	Rheumatism	___/___	Rheumatic Fever
___/___	High Blood Pressure	___/___	Hemophilia	___/___	Glaucoma	___/___	Epilepsy/Convulsions
___/___	Low Blood Pressure	___/___	H.I.V. or A.I.D.S.	___/___	Joint Replacement	___/___	Fever Blisters
___/___	Stroke	___/___	Transfusion	___/___	Organ Transplant	___/___	Bleeding Problems

Are you pregnant? ___Yes ___No What Tri-mester:_____ Complications?:________ OB Dr.'s Name and Phone____

PHYSICIAN'S NAME: ____**PHONE**_____________________________________

PLEASE LIST ANY MEDICATIONS OR ATTACH LIST____

____

____

PLEASE CHECK AND ELABORATE IN THE SPACE PROVIDED:

ALLERGIES: ____Yes ____No ____ Drugs/Medicines______________________________________ ____LATEX _____ Foods___________________________

DRUGS OR ALCOLHOL problems in the past? _____Yes ______ No Do you **SMOKE** or **CHEW TOBACCO** now or in the past? _____Yes ______No

THE ABOVE INFORMATION IS TRUE AND CORRECT *TO THE BEST OF MY KNOWLEDGE*:

____Relationship: ____________________________**DATE**__________________________
Patient Signature OR Responsible Party

DOCTOR'S SIGNATURE____ **DATE**____

MEDICAL UPDATES:
DATE **CHANGES** **DOCTOR'S SIGNATURE**

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