



Patient Name _____

Date _____

Date of Birth _____

Address _____ City _____

Postal Code _____

Phone Number (check which is preferred)

Home _____

Work _____

Cell _____

Email _____

For appointment reminders which do you prefer?

Text

Email

Phone Call

Primary Physician:

Name _____

Phone # _____

Address _____ City _____

Postal Code _____

Name of Medical Specialist and their specialty: _____

Phone # _____

Address _____ City _____

Postal Code _____

Emergency Contact: _____ Relationship: _____

Phone #(home) _____

Phone #(cell) _____

Person responsible for account: _____

Dental Insurance: Yes No

Name of Insurance Company _____

Group Policy Number _____

Cert/ID Number _____

I. Are you being treated for any medical condition at the present or have you been treated within the last year?

Yes No Not Sure
Please explain:

2. Has there been any change in your general health in the past year?

Yes No Not Sure
Please explain:

3. When was your last medical checkup?

4. Do you have any conditions that could affect your immune system e.g. leukemia, HIV infection +/- tested, lupus?

Yes No Not Sure

5. Are you undergoing any therapies that could affect your immune system e.g. radiotherapy or chemotherapy?

Yes No Not Sure

6. Are you currently taking any steroids or cortisone?

Yes No Not Sure

7. Do your ankles, feet or hands swell?

Yes No Not Sure

8. Are you allergic to any medications?

Yes No Not Sure

List medications:

9. Are you allergic to any of the following:

Latex
Rubber
Metal
No
Not Sure

10. Are you allergic to any foods?

Yes No Not Sure

Please explain:

11. Do you have any other allergies that we should be aware of?

Yes No Not Sure

Please explain:

12. Have you ever had any peculiar or adverse reactions to any medicines or injections?

Yes No Not Sure
Please explain:

13. Are you taking or have you ever taken osteoporosis medications (e.g. Fosamax, Actonel)?

I am currently taking
I was previously taking but am no longer
No
Not Sure

14. Are you currently taking any prescription medications?

Yes
Yes and I brought a list
No
Not Sure
Provide details:

15. Have you been advised against taking any medications?

Yes No Not Sure
Provide details:

16. Are you taking any non-prescription drugs?

Yes
Yes and I brought a list
No
Not Sure
Provide details including frequency:

17. Do you take any recreational drugs on a regular basis?

Yes No Not Sure
Provide details including frequency:

18. Are you taking any herbal supplements of any kind?

Yes
Yes and I brought a list
No
Not Sure
Provide details including frequency:

19. Do you have Diabetes?

I have Type 1 Diabetes
I have Type 2 Diabetes
No
Not Sure

If so - How is it controlled?

Diet
Medication

20. Do you have or have you ever had any of the following?

Arthritis/Rheumatism	Lung disease/Emphysema
Asthma	Malignant hyperthermia
Cancer	Mitral valve prolapse
Chest pain, angina	Pacemaker
Crohn's	Rheumatic/Scarlet fever
Drug/alcohol dependency	Seizures (Epilepsy)
Fainting or dizzy spells	Shortness of breath
Glaucoma	Sickle cell disease
Head/neck injuries	Sinus trouble
Heart attack	Stomach ulcers
Heart murmur	Stroke
Hepatitis A	Thyroid disease
Hepatitis B	Tuberculosis
Hepatitis C	Herpes
Hyperglycemia	Psychiatric/mental disorders
Hypoglycemia	Hay Fever
Jaundice	Joint Replacement
Kidney disease	None of the above
Liver disease	

21. Do you have a history of any immuno-compromising disease or condition?

Yes No Not Sure

Please explain:

22. Do you have or have you had any conditions or diseases not previously listed that we should be aware of?

Yes No Not Sure

Please explain:

23. Are there any diseases or medical problems that run in your family?

Cancer
Diabetes
Heart Disease
Malignant Hyperthermia
Other
Not sure
No

Please explain:

24. Do you have a bleeding problem or bleeding disorder?

Yes No Not Sure

25. Do you have or have you ever had a replacement or repair of a heart valve or stent?	Yes	No	Not Sure
26. Do you have or have you ever had an infection of the heart (e.g. infective endocarditis)?	Yes	No	Not Sure
27. Have you had a transplant (heart, lungs, organs)?	Yes	No	Not Sure
28. Do you have a heart condition from birth (e.g. congenital heart disease/lesions)?	Yes	No	Not Sure
29. Do you have or have you ever had any heart or blood pressure problems?	Yes	No	Not Sure
30. Do you have a prosthetic or artificial joint?	Yes	No	Not Sure
31. Have you ever been hospitalized for any illnesses or operations?	Yes	No	Not Sure
	Please explain: _____ _____		
32. Have you ever had any injury or surgery to your face or jaws?	Yes	No	Not Sure
33. Do you smoke or chew tobacco products?	Yes	No	Not Sure
34. Are you nervous during dental treatment?	Yes	No	Not Sure
35. Is there anything else about your health we should be made aware of?	Yes	No	Not Sure
	Please explain: _____ _____		
36. Do you wish to speak to the doctor privately about any problem or medical condition?	Yes	No	Not Sure
37. Has the child patient recently had any of the following?	Chicken pox Measles Mumps Strep throat Tonsilitis None of the above/Not applicable		
38. Are there any immunizations that the child is not up to date with?	Yes	No / Not Applicable	Not Sure
39. For women only: Are you breastfeeding?	Yes	No / Not Applicable	
40. For women only: Are you pregnant?	Yes	No / Not Applicable	Not Sure
	What is your expected delivery date? _____		

Are you experiencing any dental problems? Yes No

Date of your last Dental Visit: _____

Dental Cleaning: _____

When were X-rays taken last? _____

1. Have you been seeing a dentist regularly?	Yes	No
2. Are there any growths or sore spots in your mouth?	Yes	No
3. Have you noticed any loose teeth, or have any of your teeth shifted?	Yes	No
4. Does food get caught between your teeth?	Yes	No
5. Are any of your teeth sensitive to heat, cold, sweets or pressure?	Yes	No
6. Have you been advised to take antibiotics before a dental appointment?	Yes	No
7. Do you use dental floss, proxabrush, or stimudents?	Yes	No
If yes, how often? _____		
8. How often do you brush your teeth? _____		
Do you feel that you have bad breath?	Yes	No
9. Have you ever had one of the following?		
Periodontal treatment? (<i>treatment of the gums</i>) _____	Yes	No
Orthodontic treatment? (<i>to straighten or realign teeth</i>) _____	Yes	No
A bite plate or any other appliance? _____	Yes	No
Your bite adjusted or teeth ground? _____	Yes	No
Oral surgery? (<i>surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?</i>) _____	Yes	No
10. JAW PROBLEMS - Do you have any of the following?		
Popping/clicking in your jaw joints? _____	Yes	No
Pain in your jaw joints, around your ear, or side of your face? _____	Yes	No
Difficulty in opening or closing? _____	Yes	No
Pain when teeth are clenched? _____	Yes	No
Pain/difficulty in chewing? _____	Yes	No
11. Do you have any of the following habits?		
Clenching or grinding your teeth while awake or asleep? _____	Yes	No
Biting your cheeks or lips regularly? _____	Yes	No
Breathing through your mouth while awake or asleep? _____	Yes	No
Hold foreign objects with your teeth (pencils, nails, pipes, pins, fingernails)? _____	Yes	No

- | | | |
|--|-----|----|
| 12. Do you have any emotional concerns about having dental treatment? | Yes | No |
| 13. Are you happy with the appearance of your teeth?
If no, what would you like to see changed? _____ | Yes | No |
| 14. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or do you have any questions or concerns? | Yes | No |
-

General Release

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

Print Name of Guardian _____

Signature Patient Parent Guardian) _____

Reviewed by Treating Dentist _____

Date _____

