

Section I: Patient Information **Date** _____

Name: _____ **I prefer to be called:** _____

Date of Birth: _____ **Email Address** _____

Spouse or Parent's Name: _____

Section II Medical History

Is your current physical health: Good _____ Fair _____ Poor _____

Do you currently have a primary care physician/provider? Yes _____ No _____

Date you last saw your primary care physician/provider _____

Name and contact number of primary care physician/provider _____

For Women: Are you pregnant? Yes _____ No _____ **Are you nursing?** Yes _____ No _____

Are you using a prescribed method of birth control? Yes _____ No _____

Do you smoke or use tobacco in any other form? Yes _____ No _____ **# Packs** _____

Have you had any metal rods, pins or implants? Yes _____ No _____ **Where/when placed?** _____

Are you taking any prescription/over-the-counter or herbal supplemental drugs? Yes _____ No _____

List of Medicines: _____

Past Surgeries and Dates: _____

Have you ever taken Fosamax or any other bisphosphonate (prescription Calcium supplement)? Yes _____ No _____

Have you ever had any of the following diseases or medical problems?

Y or N Abnormal Bleeding	Y or N Epilepsy/Seizures	Y or N High Blood Pressure	Y or N Rheumatic Fever
Y or N Alcohol/Drug Abuse	Y or N Fainting Spells	Y or N HIV/AIDS	Y or N Scarlet Fever
Y or N Anemia	Y or N Frequent Headaches	Y or N Kidney Problems	Y or N Shingles
Y or N Arthritis	Y or N Glaucoma	Y or N Liver Disease	Y or N Sickle Cell Disease
Y or N Artificial Bones	Y or N Hay Fever	Y or N Low Blood Pressure	Y or N Sinus Problems
Y or N Artificial Joints	Y or N Heart Attack	Y or N Lupus	Y or N Stroke
Y or N Artificial Heart Valve	Y or N Heart Murmur	Y or N Mitral Valve Prolapse	Y or N Thyroid Problems
Y or N Cancer	Y or N Heart Surgery	Y or N Osteoporosis/Paget's	Y or N Tuberculosis
Y or N Congenital Heart Defect	Y or N Hemophilia	Y or N Pacemaker	Y or N Ulcers
Y or N Diabetes	Y or N Hepatitis	Y or N Psychiatric Problems	Y or N Venereal Disease
Y or N Emphysema	Y or N Herpes	Y or N Radiation/Chemotherapy	Y or N Asthma

Are you allergic to any of the following?

Y or N Aspirin	Y or N Dental Anesthetics	Y or N Latex	Y or N Tetracycline
Y or N Codeine	Y or N Erythromycin	Y or N Penicillin	Y or N Other

OTHER CONDITION OR ALLERGY NOT LISTED ABOVE? _____

Section III Dental History

Is your current dental health: Good _____ Fair _____ Poor _____ **Do you like your smile?** Yes _____ No _____

Do you require antibiotics before any dental treatment is performed? Yes _____ No _____

What is your chief complaint and why are you here today? _____

Are you currently in pain? Yes _____ No _____ **Are your teeth sensitive to temperature or pressure?** Yes _____ No _____

Have you ever had a serious or difficult problem associated with any previous dental work? Yes _____ No _____ **Have you ever had a gum treatment?** Yes _____ No _____ **Do your gums ever bleed?** Yes _____ No _____

Do you or have you ever experienced pain/discomfort in your jaw joint? (TMJ/TMD) Yes _____ No _____

How many times a week do you floss your teeth? _____ **Brush your teeth?** _____

What type of bristles are on your toothbrush? Soft _____ Medium _____ Hard _____

How long do you use a toothbrush before replacing it? _____

Have you ever lost any teeth? Yes _____ No _____, **why?** _____

Signature of Patient or Parent _____ **Date** _____