DENTAL HISTORY

What is your chief complaint about your mouth? _________________
Are you currently in pain? Yes or No if YES, please explain ___________
Is your current dental health ____Good ____Fair ____Poor
Do you floss daily? __YES __NO Do you brush daily? __YES __NO
Do your gums ever bleed? __YES __NO Do your gums itch? __YES __NO
Do your jaws click/pop? __YES __NO
Do you grind your teeth? __YES __NO
Do you have red/swollen gums? __YES __NO
Do you get fever blisters? __YES __NO

Are your teeth sensitive to cold, hot, or anything else? ___________
Are any of your teeth loose? ___ Yes ___ No
Do you still have your wisdom teeth? ____ Yes ___ No
Previous dentist _______________Present dentist _______________
When did you have your teeth cleaned last? ____________________
Have you ever had periodontal treatment? ___Yes ___No
If so, when ___________ Doctor's name ______________________
Are you currently taking any antibiotics? ___ Yes ___ No
What are you taking? ____________________________________

MEDICAL HISTORY

Primary Care Physician's Name: __________________________ Telephone: ___________________________________
In addition to my PCP, I am currently under the care of the following specialist(s):
Name: _________________________ Specialty: ______________________ Telephone: ___________________
Name: _________________________ Specialty: ______________________ Telephone: ___________________
Have you had any major illness, operation, or hospitalization in the past five years? ____ Yes ____ No
If so, what and when? ____
Do you smoke or use any form of tobacco? ____ Yes ____ No What type? ______________ How often? __________
Have you ever taken Phen-Fen, Redux, or Pondimin? ____ Yes ____ No
Female Patients: Pregnant or Possibly? ________ Expected due date: ___________ Currently nursing? _______
Taking birth control pills? _____

Do you have or experienced any of the following? Check all that apply

___ Abnormal Bleeding	___ Alcohol Abuse	___Anemia	___ Arthritis
___Artificial Bones/Joints	___ Artificial Valves	___ Asthma	___ Blood Transfusion
___Cancer type_______	___ Chemotherapy	___ Chicken Pox	___ Colitis
___Congenital Heart Defect	___ Diabetes type _____	___Difficulty Breathing	___Drug Abuse
___Emphysema	___ Epilepsy	___ Fainting Spells	___ Gall Bladder stones
___Glaucoma	___ Hay Fever	___ Headaches	___ Heart Attack
___Heart Surgery	___ Hemophilia	___Hepatits __A __B __ C	
___ Herpes	___ High Blood Pressure	___ HIV/AIDS	___ Kidney Problems
___ Liver Disease	___ Low Blood Pressure	___ Lupus	___ Mitral Valve Prolapse
___ Pacemaker	___ Persistent Cough	___ Psychiatric Treatment	
___ Radiation Treatment	___ Rheumatic Fever	___ Scarlet Fever	___ Seizures
___ Shingles	___ Sickle Cell Disease	___ Sinus Problems	
___Steroid Therapy	___ Stroke	___ Thyroid Problems	
___ Tonsillitis	___ Tuberculosis (TB)	___ Ulcers	___ Venereal Disease

Have you ever been told to take antibiotics **prior** to your **dental appointment** or **surgery**? ___ Yes ___ No
If so, what: ____
Please list ALL medications, OTC drugs, and herbal/natural or homeopathic you are presently taking:

Are you allergic to any of the following? Check all that apply

___ Aspirin ___ Barbiturates ___ Codeine ___ Dental Anesthetics ___ Erythromycin
___ Jewelry/Metals ___ Latex ___ NSAIDS (anti-inflammatory) ___ Penicillin
___Sedatives (valium or other tranquilizers) ___ Sulfa Drugs ___ Tetracycline
___ Other _________________________

Our office HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.
I affirm that the information I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I have been offered a copy of the **Notice of Privacy Practices**.

Signature: ____ Date: ___________________
(parent or guardian if minor)