Patient Name: _____ **Date:** _____

Please list the problems or concerns which have prompted you to seek treatment:

1	3
2	4

Dental History

General Dentist	
Name	
Address	
City: State: Zip:	

Date of last dental exam:	
Date of next dental exam:	
Cavities?	
Gum Disease?	

Has the patient ever had or currently have:		Teeth involved
Avulsed/knocked out teeth	• No • Yes	
Injury to the jaws or mouth	• No • Yes	
Jaw pain	• No • Yes	
Abscess	• No • Yes	
Broken Fillings	• No • Yes	
Sensitivity to hot or cold	• No • Yes	
Sensitivity to sweets	• No • Yes	
Sensitivity when biting	• No • Yes	

Has the patient ever had or currently have:	
Implants	• No • Yes
Bad breath	• No • Yes
Sores or growths in the mouth	• No • Yes
Root Canal	• No • Yes

Can the pt take Tylenol?	• No • Yes
Can the pt take Ibuprofen?(Advil)	• No • Yes

Medical History

Patient's Physician	
Name	
Address	
City: State: Zip:	

PREMEDICATION REQUIRED PRIOR TO DENTAL TX? • No • Yes

LIST ALL MEDICATIONS CURRENTLY BEING TAKEN: _____

_____

_____

Has the patient ever had or currently have:		Medications
Heart/Circulation Problems:	• No • Yes	
Murmer	• No • Yes	
Mitral Valve Prolapse	• No • Yes	
MI	• No • Yes	
Arrythmias	• No • Yes	
High Blood Pressure	• No • Yes	
Stroke	• No • Yes	
Other: _____	• No • Yes	
Lung Problems:	• No • Yes	
Asthma	• No • Yes	
Allergies	• No • Yes	
Shortness of Breath	• No • Yes	
Other: _____	• No • Yes	
Infectious Diseases:	• No • Yes	
Canker sores	• No • Yes	
Chicken Pox	• No • Yes	
Measles	• No • Yes	
Mumps	• No • Yes	
Mononucleosis	• No • Yes	
Tuberculosis	• No • Yes	
Hepatitis •A •B •C	• No • Yes	
HIV	• No • Yes	
Other: _____	• No • Yes	
Kidney Problems	• No • Yes	
Liver Problems	• No • Yes	
Headaches	• No • Yes	

Has the patient ever had or currently have:		Medications
Blood Dyscrasias:	• No • Yes	
Anemia	• No • Yes	
Hemophilia	• No • Yes	
Other: _____	• No • Yes	
Systemic Diseases:	• No • Yes	
Thyroid Problems	• No • Yes	
Arthritis	• No • Yes	
Diabetes	• No • Yes	
Nervous/Psychiatric Problems	• No • Yes	
Epilepsy	• No • Yes	
Allergies	• No • Yes	
Other: _____	• No • Yes	
Eating Disorders	• No • Yes	
Anorexia	• No • Yes	
Bulimia	• No • Yes	
GI Reflux	• No • Yes	
Cancer:_____	• No • Yes	
Chemotherapy	• No • Yes	
Radiation Therapy	• No • Yes	
Miscellaneous	• No • Yes	
Surgery:_____	• No • Yes	
Artificial Heart Valves	• No • Yes	
Artifical Joints	• No • Yes	
Cleft Lip and/or Palate	• No • Yes	
Birth Defects	• No • Yes	
Other:_____	• No • Yes	

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

Patient Signature (Parent if minor)_____ **Date:**_____