Patient Name_____**Date**_____

Primary reason for this dental appointment: □ Examination □ Emergency □ Consultation

Dental History

-Do you have a specific dental problem? Describe_____ Yes No
-Do you have dental examinations on a routine basis? Last visit_____ Yes No
-Do you think you have active decay or gum disease?_____ Yes No
-Do you brush and floss on a routine basis?_____Yes No
-Do you ever have clicking, popping, or discomfort in the jaw joint? Do you brux or grind?_____ Yes No
-Do you smoke or chew?_____ Yes No
-Any sores or growths in your mouth? Discuss_____ Yes No
-Name of previous dental office:_____
-Date of last full mouth x-rays (16 small films or panoramic)_____
-Is there anything you would like to improve about your smile?_____.
-Would you like whiter teeth? Yes No

Medical History

-Are you under a physician's care now? Why?_____.
Who?_____ Phone_____
-Have you ever been hospitalized or had a major operation? Yes No Discuss_____.
_____.
-What medications, vitamins, pills or drugs are you currently taking (if any):_____
_____
_____.
-Are you **allergic** to any medications or substances? Yes No (*Please check box below*)
□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex Rubber □ Milk
□ Other_____
-***Women*** (please check): □ Pregnant/trying to get pregnant □ Nursing

-Do you now or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes. (**If yes to any of the starred conditions, please call prior to your appointment…pre-medication or changes in medication may be required.*)

□ Heart disease/surgery	□ Pain in jaw joints	□ Allergies (pollen/dust)
□ Rheumatic fever*	□ Rheumatoid arthritis	□ Nervousness
□ Coronary stent*	□ Osteoporosis	□ Hives/rash
□ Pulmonary shunt*	□ Joint replacement (screws/plates)	□ Angina/chest pain
□ Heart murmur or defect*	□ Frequent cough	□ Scarlet fever
□ Congenital heart disorder*	□ Arthritis/gout	□ Chemotherapy
□ Artificial heart valve*	□ Tuberculosis	□ Thyroid disease
□ Heart pacemaker*	□ Ulcers	□ Kidney problems
□ Mitral valve prolapse*	□ Stomach intestinal disease	□ Renal dialysis
□ Heart attack/failure	□ G.E.R.D./acid reflux	□ Liver disease
□ Irregular heartbeat	□ Diabetes	□ Hepatitis A (infectious)
□ Bacterial endocarditis*	□ Hypoglycemia	□ AIDS/HIV Positive
□ Lung disease	□ Bruise easily/blood disease	□ Cold/canker sores
□ Asthma	□ Recent blood transfusion	□ Hepatitis B or C
□ Emphysema or C.O.P.D.	□ Autoimmune disease	□ Tattoos/Body piercing
□ X-ray (radiation) treatments	□ Sinus trouble	□ Drug addiction/alcoholism
□ Cancer	□ High blood pressure	□ Herpes
□ Leukemia	□ Low blood pressure	□ Epilepsy/convulsions
□ Tumors/growths	□ Fainting or dizziness	□ Alzheimer's disease

□ Bone density medications or bisphosphonates: (Zometa, Aredia, Reclast, Fosamax, Actonel, Boniva)

-Have you ever had any other serious illness not checked above? Discuss_____
_____.

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.
X_____ Date_____
Patient Signature (Parent or Guardian)
Reviewed by Doctor_____ Date_____

Patient Consent Form HIPAA

I hereby acknowledge that a copy of this office's *Notice of HIPAA* rights has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

Please print patient name:_____

Signature:_____ Date:_____

Medical Updates

Date **New Findings/Medications**

_____
_____
_____
_____
_____

DENTAL & MEDICAL HISTORY