Medical History

Are you currently under the care of a physician? ❑Yes ❑No If yes, please explain: _____

_____

Have you had any metal rods, pins or implants placed? ❑Yes ❑No

Are you taking any medications? ❑Yes ❑No (including bisphosphonates)

Please list each one:_____

Do you have, or have had any of the following? If no please mark "none of the above"

Y	Y	Y
❑ Allergies	❑ Epilepsy	❑ Mitral Valve Prolapse
❑ Anemia	❑ Fainting Spells	❑ Pace Maker
❑ Arthritis	❑ Frequent Headaches	❑ Rheumatic Fever
❑ Artificial Heart Valve	❑ HIV+ AIDS	❑ Seizures
❑ Asthma	❑ Heart Attack or Surgery	❑Shingles
❑ Bleeding Problems	❑ Heart Murmur	❑Sinus Problems
❑ Cancer	❑ Hemophilia	❑ Sleep Apnea
❑ Chemotherapy or Radiation	❑ Hepatitis A, B, C	❑ Stroke
❑ Congenital Heart Defect	❑ High Blood Pressure	❑ Thyroid Problems
❑ Diabetes	❑ Joint Replacement	❑ Ulcers
❑ Difficulty Breathing	❑ Liver Disease	❑ **None of the above**
❑ Drug or Alcohol Abuse	❑ Low Blood Pressure	Other: _____

Allergies

Y		
❑ Aspirin	❑ Metals	**If Female**, please answer
❑ Codeine	❑ Penicillin	❑ ❑ Are you taking birth control Pills?
❑ Dental Anesthetics	❑ Tetracycline	❑ ❑ Are you pregnant? If so, # of weeks _____
❑ Erythromycin	❑**None of the above**	❑ ❑ Are you nursing?
❑ Latex	Other:_____	

Dental History

How may we help you today? _____

Do you require antibiotics before dental treatment? ❑Yes ❑No

Do you like your smile? ❑Yes ❑No

Are your teeth sensitive to hot, cold or anything else? ❑Yes ❑No

Have you ever had a serious/difficult problem with any previous dental work? ❑Yes ❑No

Have you ever had any unfavorable dental experiences? ❑Yes ❑No

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Would you would like discuss any of the following during your visit? ❑Teeth Whitening ❑Veneers/Lumineers

❑Invisalign ❑Implants ❑Amalgam removal ❑Night Guard ❑Traditional Orthodontics

Person to contact in case of emergency: _____ Phone number ( ) _____

First Last

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____