Account Number _____

DENTAL HEALTH INFORMATION - CONFIDENTIAL

Although dentists primarily treat the area in and around the mouth, it is important for us to know all facts relative to your present and past health. Certain medications and health conditions could have an important interrelationship with the treatment that you will be receiving. The following information is confidential.

Patient's Name: _____ Date of Birth _____

Last Physical Date: _____ Physician's Name & Phone #: _____

Reason for today's visit? _____ ***Work Related Injury? Yes No***

Have you been under the care of a physician? _____ Date of last dental visit: _____

Have you ever been hospitalized? _____ Date of last dental x-rays: _____

Ever had Novocain or other local anesthetic? _____ If wearing dentures, age of dentures: _____

Are you taking Aspirin or any other anticoagulant therapy of any kind? _____ If playing sports, do you need a mouth guard? _____

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? _____

Have you had an adverse reaction or become ill to penicillin, aspirin, codeine, local anesthetics, **latex**, metals, or any other medication? YES NO

List any medications you are allergic to:

1. _____ 3. _____
2. _____ 4. _____

List any medications you are taking including non-prescription drugs including herbals/vitamins:

1. _____ 3. _____
2. _____ 4. _____

Do you have a history of:	YES	NO		YES	NO		YES	NO
Rheumatic Fever	( )	( )	Venereal Disease	( )	( )	Sinus Problems	( )	( )
Heart Murmur	( )	( )	HIV Positive/Aids	( )	( )	Cancer (Type:)	( )	( )
Mitral Valve Prolapse	( )	( )	Blood Transfusion	( )	( )	Chemotherapy	( )	( )
Heart Problem ( )	( )	( )	Excessive Bleeding	( )	( )	Radiation Treatment	( )	( )
Pace Maker/Heart Surgery	( )	( )	Anemia	( )	( )	Use of Tobacco Products	( )	( )
High Blood Pressure	( )	( )	Hepatitis (Type)	( )	( )	Drug Addiction	( )	( )
Low Blood Pressure	( )	( )	Liver Disease	( )	( )	Alcoholism	( )	( )
Diabetes	( )	( )	Kidney Disease	( )	( )	Psychiatric Treatment	( )	( )
Stroke	( )	( )	Dialysis	( )	( )	Mouth sores/growths	( )	( )
Lung Disease	( )	( )	Thyroid Disease	( )	( )	Teeth Grinding/Clenching	( )	( )
Breathing Problems	( )	( )	Epilepsy or Seizures	( )	( )	Pain in your jaw (TMJ)	( )	( )
Tuberculosis (TB)	( )	( )	Fainting or Dizzy Spells	( )	( )	Any type of Implant	( )	( )
Asthma	( )	( )	Ulcers or Stomach Problems	( )	( )	Any type of Transplant	( )	( )
Allergies or Hives	( )	( )	Arthritis	( )	( )	Any Artificial Hip, Knee or other Joint	( )	( )

Other Disease or Illness: _____

WOMEN	YES	NO
Is there a possibility of pregnancy?	( )	( )
Estimated Delivery Date _____/_____/_____		
Are you nursing?	( )	( )
Are you taking any birth control prescriptions?	( )	( )

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge.

Patient's Signature _____ Date _____ Dr's. Signature/Medical History Review _____ Date _____

Patient's Signature _____ Date _____ Dr's. Signature/Medical History Review _____ Date _____