Time 12:28 PM | Giebenhain Dental | Date 8/28/2019

NEW PATIENT (2019)

Patient Name: | Birth Date: | Date Created:

When was your last dental visit?

Did you have dental x-rays taken at your last visit? Yes No

Are you aware of any dental issues? If yes, please explain. Yes No If yes

Is there anything you'd like to chane about your smile? Yes No If yes

Are you interested in straightening your teeth? Yes No

Are you interested in whitening your teeth? Yes No

How often do you brush your teeth?

How often do you floss your teeth?

Although dental personnal primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking,

Please check any of the following that apply to you:

Bad breath	Yes No	Dry mouth	Yes No	Food collects	Yes No
Grinding/clenching	Yes No	Gums bleed	Yes No	Gum disease	Yes No
Jaw click/pop	Yes No	Jaw pain	Yes No	Mouth sores	Yes No
Sensitive teeth	Yes No	Smoker	Yes No	Uses chewing tobacco	Yes No

Are you under the care of a physician at this time? Please tell us for what. Yes No If yes

Have you ever been hopitalized or had a major operation? Yes No If yes

Have you had a serious head or neck injury? If yes, when. Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? If yes, please list. Yes No If yes

Are you required to pre-medicate with antibiotics before dental treatment? Please tell us for what. Yes No If yes

Are you taking any medications, pills or drugs? If yes, please list. Yes No If yes

Do you snore? Yes No

Have you been diagnosed with sleep apnea? Yes No

Do you wear a C-PAP? Or been told to? Yes No

Have you had a sleep study? Or been told to? Yes No

Women are you...

Pregnant/trying to get pregnant?	Yes No	Nursing?	Yes No	Taking oral contraceptives?	Yes No

Are you allergic to any of the following?

Acrylic	Yes No	Aspirin	Yes No	Codeine	Yes No	Latex	Yes No
Local anesthetics	Yes No	Metal	Yes No	Penicillin	Yes No	Sulfa	Yes No

Other allergies? Yes No If yes

Have you been treated for chemical dependency? If yes, please explain. Yes No If yes

Do you have, or have you had, any of the following?

Acid reflux/GERD	Yes No	ADD/ADHD	Yes No	AIDS/HIV positive	Yes No	Anaphylaxis	Yes No
Anemia	Yes No	Angina/chest pain	Yes No	Arthritis/Gout	Yes No	Artificial heart valve	Yes No
Artificial joint	Yes No	Asthma	Yes No	Blood disease	Yes No	Breathing problems	Yes No
Bruise easily	Yes No	Cancer	Yes No	Chemotherapy/Radiation	Yes No	Cold sores/Fever blisters	Yes No
Diabetes	Yes No	Easily winded	Yes No	Emphysema/lung disease	Yes No	Epilepsy/seizures	Yes No
Excessive bleeding	Yes No	Excessive thirst	Yes No	Fainting/dizziness	Yes No	Fibromyalgia	Yes No
Frequent cough	Yes No	Frequent headaches	Yes No	Heart attack/failure	Yes No	Heart disease	Yes No
Heart murmur	Yes No	Heart pacemaker	Yes No	Hemophelia	Yes No	Hepatitis	Yes No
Herpes	Yes No	High blood pressure	Yes No	High cholesterol	Yes No	Hypoglycemia	Yes No
Irregular heartbeat	Yes No	Kidney disease	Yes No	Leukemia	Yes No	Liver disease	Yes No
Low blood pressure	Yes No	Memory loss	Yes No	Mental health care	Yes No	Mitral valve proplapse	Yes No
Narcolepsy	Yes No	Osteoperosis	Yes No	Renal dialysis	Yes No	Rheumatic fever	Yes No
Rheumatism	Yes No	Sickle cell disease	Yes No	Sinus problems	Yes No	Stroke	Yes No
Thyroid disease	Yes No	Tuberculosis	Yes No	Tumors/growths	Yes No	Ulcers	Yes No

Have you ever had any serious illness not listed about? Yes No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____