Please answer all questions by circling YES or NO and filling in blanks where needed.
A parent or guardian must complete the answers for a child under 18 years.
All answers are confidential.

Name ____________________________________ ***M___ F___ Date of Birth*** __________________

Why did you come to the dentist today? ____

____

Dental History

1. When was your last visit to a dentist? ____
2. Were you seen by the dentist for regular or emergency visits? ***Regular*** ***Emergency***
3. Have you or are you experiencing any of the following:

Gums that bleed when you brush your teeth:	***Yes***	***No***	
Red, puffy, swollen or tender gums:	***Yes***	***No***	
Gums that have pulled away/receded:	***Yes***	***No***	
Pus between teeth or gums:	***Yes***	***No***	
Loose or separating teeth	***Yes***	***No***	
Change in your bite:	***Yes***	***No***	
Change in the fit of your dentures	***Yes***	***No***	***NA***
Persistant bad breath	***Yes***	***No***	
4.Do you Smoke?	***Yes***	***No***	***How Much?*** ____________

5. Please list what you do not like about your smile and what you would like to change?
____
____
____

Medical History

1. Name and address of your MEDICAL doctor _______________________________________
2. Date of your last MEDICAL examination ______________________ ***Reason*** _______________
3. Do you have any medical conditions? ____
____
4. Please list all medications and vitamins_______________________________________
____
5. Have you ever taken any of the following:

Antibiotics	***Yes***	***No***	***Drugs for Heart Conditions***	***Yes***	***No***
High Blood Pressure Medications	***Yes***	***No***	***Nitroglycerin***	***Yes***	***No***
Anticoagulants (Blood Thinners, Coumadin)	***Yes***	***No***	***Anti-histimines (allergy pill)***	***Yes***	***No***
Steroids (Prednisone, Cortisone)	***Yes***	***No***	***Oral Contraceptives***	***Yes***	***No***
Hormone Supplements	***Yes***	***No***	***Anti-seizure Medications***	***Yes***	***No***
Antidepressants/Anti-Anxiety (Zoloft)	***Yes***	***No***	***Sedatives***	***Yes***	***No***
Insulin/Diabetes Meds	***Yes***	***No***	***Bisphosphinates (Fosamax)***	***Yes***	***No***

Other_________________________________

6. Have you ever had a serious illness or operation? ___________________________________

7. Have you ever been hospitalized? ***Yes*** ***No*** ***Why?***______________________________

PLEASE COMPLETE OTHER SIDE

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

Rheumatic Fever	*Yes*	*No*	*Heart Valve Replacement*	*Yes*	*No*
Rheumatic Heart Disease	*Yes*	*No*	*Heart Disease (circle all that apply)*		
Chest Pain or Pressure	*Yes*	*No*	*Heart Trouble*	*Stroke*	
Chest Pain at Rest or During Sleep	*Yes*	*No*	*Heart Attack*	*Murmur*	
Shortness of Breath	*Yes*	*No*	*Angina*	*Click*	
Ankle Swelling	*Yes*	*No*	*Arythmia*	*Fainting*	
Sleep Apnea	*Yes*	*No*	*High Blood Pressure*		
Snoring	*Yes*	*No*	*Low Blood Pressure*		
Heart Murmur	*Yes*	*No*	*High Cholesterol*		
Mitral Valve Prolapse	*Yes*	*No*	*Hip/Knee/Joint Replacement*	*Yes*	*No*
Stomach or intestinal problems	*Yes*	*No*	*Asthma*	*Yes*	*No*
Hay Fever/ Allergies	*Yes*	*No*	*Kidney Problems*	*Yes*	*No*
Skin Conditions	*Yes*	*No*	*Dialysis*	*Yes*	*No*
Seizures	*Yes*	*No*	*Tuberculosis*	*Yes*	*No*
Diabetes	*Yes*	*No*	*Persistent Cough*	*Yes*	*No*
Jaundice / Liver Disease	*Yes*	*No*	*Coughing Blood*	*Yes*	*No*
Hepatitis A B C	*Yes*	*No*	*HIV/ AIDS*	*Yes*	*No*
Cancer	*Yes*	*No*	*Radiation Therapy*	*Yes*	*No*
Chemotherapy	*Yes*	*No*	*Venereal Disease*	*Yes*	*No*
Abnormal Bleeding	*Yes*	*No*	*Blood Transfusion*	*Yes*	*No*
Anemia	*Yes*	*No*	*Hemophilia*	*Yes*	*No*
I V Drug Abuse	*Yes*	*No*	*Drug abuse*	*Yes*	*No*
Alcoholism	*Yes*	*No*	*Birth Defects*	*Yes*	*No*
Osteoporosis	*Yes*	*No*	*Other* ______________________		

Are you presently taking:

Coumadin	*Yes*	*No*	*Daily Aspirin*	*Yes*	*No*

Have you ever taken:

Fosamax, Boneva, Aredia, Zometa or other bisphosphinate (osteoporosis drug)? *Yes* *No*

Are you allergic to or have you had an adverse reaction to any of the following:

Penicillin	*Yes*	*No*	*Iodine or X-ray Dyes*	*Yes*	*No*
Sulfa Drugs	*Yes*	*No*	*Codeine or other narcotic*	*Yes*	*No*
Aspirin	*Yes*	*No*	*Local Anesthetic*	*Yes*	*No*

Other Medication or Substance ______________________________________

Do you have any other medical condition not listed? ______________________________

Does your job expose you to x-rays or other form of radiation?	*Yes*	*No*
Are you pregnant?	*Yes*	*No*
Have you recently missed a menstrual period?	*Yes*	*No*
Are you breast feeding?	*Yes*	*No*

What is your occupation? ______________________________________

To the best of my knowledge the above information is complete true and accurate.

______________________________________ ____________________

Signature of Patient (Parent or Legal Guardian if patient is a minor) *Date*