Patient Name: _____ **Birth Date:** ___/___/___ **Date Created:** ___/___/___

Although dental personnel 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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○No If yes: _____

Have you ever been hospitalized or had a major operation? ○Yes ○No If yes: _____

Have you ever had a serious head or neck injury? ○Yes ○No If yes: _____

Are you taking any medications? ○Yes ○No If yes: _____

Do you take, or have you taken, Phen-Fen or Redux? ○Yes ○No If yes: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates? ○Yes ○No If yes: _____

Are you on a special diet? ○Yes ○No If yes: _____

Do you use tobacco? ○Yes ○No If yes: _____

Do you use controlled substances? ○Yes ○No If yes: _____

Women: Are you…

○Pregnant/ Trying to get pregnant ○Nursing ○Taking oral contraceptives

If yes: _____

Are you allergic to any of the following?

○Aspirin ○Penicillin ○Codeine ○Acrylic ○Metal ○Latex ○Sulfa Drugs ○Local Anesthetics

○Other? If yes: _____

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

- ○ AIDS/HIV Positive
- ○ Alzheimer's Disease
- ○ Anaphylaxis
- ○ Anemia
- ○ Angina
- ○ Arthritis/Gout
- ○ Artificial Heart Valve
- ○ Artificial Joint
- ○ Asthma
- ○ Blood Disease
- ○ Blood Transfusion
- ○ Breathing Problems
- ○ Bruise Easily
- ○ Cancer
- ○ Chemotherapy
- ○ Chest Pains
- ○ Cold Sore/Fever Blisters
- ○ Congenital Heart Disorder
- ○ Convulsions
- ○ Cortisone Medicine
- ○ Diabetes
- ○ Drug Addiction
- ○ Easily Winded
- ○ Emphysema
- ○ Epilepsy or Seizures
- ○ Excessive Bleeding
- ○ Excessive Thirst
- ○ Fainting Spells/Dizziness
- ○ Frequent Cough
- ○ Frequent Diarrhea
- ○ Frequent Headaches
- ○ Genital Herpes
- ○ Glaucoma
- ○ Hay Fever
- ○ Heart Attack/Failure
- ○ Heart Murmur
- ○ Heart Pacemaker
- ○ Heart Trouble/Disease
- ○ Hemophilia
- ○ Hepatitis A
- ○ Hepatitis B or C
- ○ Herpes
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Hives or Rash
- ○ Hypoglycemia
- ○ Irregular Heartbeat
- ○ Kidney Problems
- ○ Leukemia
- ○ Liver Disease
- ○ Low Blood Pressure
- ○ Lung Disease
- ○ Mitral Valve Prolapse
- ○ Osteoporosis
- ○ Pain in Jaw Joints
- ○ Parathyroid Disease
- ○ Psychiatric Care
- ○ Radiation Treatments
- ○ Recent Weight Loss
- ○ Renal Dialysis
- ○ Rheumatic Fever
- ○ Rheumatism
- ○ Scarlet Fever
- ○ Shingles
- ○ Sickle Cell Disease
- ○ Sinus Trouble
- ○ Spina Bifida
- ○ Stomach/Intestinal Disease
- ○ Stroke
- ○ Swelling of Limbs
- ○ Thyroid Disease
- ○ Tonsillitis
- ○ Tuberculosis
- ○ Tumors or Growths
- ○ Ulcers
- ○Venereal Disease
- ○ Yellow Jaundice

Have you ever had any serious illness not listed above? ○ Yes ○No

If yes: _____

Comments: _____

_____

To the best of my knowledge, the questions on the 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.

X _____ Date: _____

Signature of Patient, Parent or Guardian

Please Indicate An Answer For Each of the Following Questions:

Grind Teeth:	No	Possible	Present	Past
Bite Cheeks:	No	Possible	Present	Past
Mouth Breather:	No	Possible	Present	Past
Eating Disorder:	No	Present	Past	
Thumb Sucking:	No	Possible	Present	Past
Nail Biting	No	Frequently	Occasional	Past

IF YES TO THE FOLLOWING, PLEASE EXPLAIN:

Toothpicks:	No	Frequently_____	Occasional	Past
Chewing Gum:	No	Frequently_____	Occasional	Past
Candy:	No	Frequently_____	Occasional	Past
Soft Drinks:	No	Frequently_____	Occasional	Past
Energy/Sports Drinks:	No	Frequently_____	Occasional	Past
Cigar/Cigarette:	No	Frequently_____	Occasional	Past
Pipe:	No	Frequently_____	Occasional	Past
Chewing Tobacco:	No	Frequently_____	Occasional	Past

Other Habits:_____

Are Your Teeth Sensitive To (Please indicate where in your mouth):

Hot/Cold: No Yes: _____
Biting/Chewing: No Yes:_____
Sweets: No Yes: _____

Have you Ever Had:

Orthodontic Treatment: No Present Past - Do you wear retainers? No Yes – How often? _____
A Bite Plate/Guard: No Past Present – How often:_____
Oral Surgery/Periodontal Therapy No Yes (Explain): _____
Serious Injury to Mouth or Head: No Yes (Explain):_____

Previous Dentist:_____Date of Last Dental Visit:_____

****PLEASE HAVE PREVIOUS DENTIST SEND US YOUR MOST RECENT XRAYS****

Whom may we thank for referring you?_____

[ ] HIPPA [ ] CONSENT [ ] BWX [ ] PANO [ ] PICS [ ] PA #:_____**MED ALERTS [ ] None [ ]** _____

Xray Notes:_____
_____
CC:_____
Occl Class: R_____L_____ End:_____
____OB ____OJ Xbite:_____
Midline: Max Mand R L ___mm
TMJ: WNL / _____
S Tiss: WNL / _____
CALC:_____PLQ:_____ STN:_____
Velscope: WNL / _____
Probing: FULL / SPOT / HYG

Comments:_____
_____
_____
TX:_____
_____
1)_____
2)_____
3)_____

PRO: 30 40 50 60 **{** GROSS – 6 wk **}** **{** SRP:_____/_____3 mon **}**

#	Existing	Proposed	#	Existing	Proposed
1			17		
2			18		
3			19		
4			20		
5			21		
6			22		
7			23		
8			24		
9			25		
10			26		
11			27		
12			28		
13			29		
14			30		
15			31		
16			32		

[ ] Existing [ ] Med Hx/Alerts [ ] Registration [ ] Photos [ ] X-Rays [ ] Notes