

General health (please check): Excellent Good Fair Poor Physician's name _____

Address _____ Phone _____ Last complete physical _____

Date of last visit _____ Reason _____ Med. Ins. BC/BS Other _____

Are you sensitive or allergic to: Aspirin Penicillin Codeine Other _____

Local injected Anesthetics (Novocaine / Lidocaine) Other Medications _____

MEDICAL HISTORY

Have you ever had or ever been treated for:

Heart disease / Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alzheimers Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolonged bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart valve replacement surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital heart lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal blood pressure High / Low	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold sores on your mouth or lips	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis / Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dialysis for kidney problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint replacement surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you get out of breath easily?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke or use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No
(Women) Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Serious accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take birth control pills?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Malignancies / Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma or hay fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Venereal Disease (Syphilis, Gonorrhea)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic fever with valve damage.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Feet / Ankle / Hands	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex Allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No

Has there been a change in your health in the last year?..... Yes No

Are you taking any medication now? Yes No Please list the medication and purpose _____

Has your physician ever advised you to take antibiotics prior to dental appointments?..... Yes No

Are you presently taking medication or aspirin for blood thinning purposes?..... Yes No

Have you ever taken oral or IV medication (bisphosphonates) for osteoporosis (bone density) or chemotherapy related to bone cancer? Yes No

Please describe any current medical treatment including drugs, pending surgery, recent injuries and illnesses, or any other medical information we should be aware of that has not been discussed or not listed above.

DENTAL HISTORY

Do you clench or grind your teeth during the day or night? Yes No

Have you ever had pain in your jaw joint or your face (in and about your ears)?..... Yes No

Do you have any difficulty opening your mouth widely and / or does your jaw click?..... Yes No

Have you ever had an injury to your face, neck, or jaws?..... Yes No

Do you suffer from frequent or severe headaches, neck, or back pain?..... Yes No

Do you have an unpleasant odor, or taste, in your mouth?..... Yes No

Do your gums bleed when brushing and / or have you been told you have gum disease?..... Yes No

Please add anything you feel is important for the doctor to know _____

What would you like to change in your smile; whiter teeth, straighten your teeth, fill in missing spaces? Please tell us: _____

Previous Dentist's Name _____ Address _____ Phone _____

Reason for leaving last Dentist _____ Date of last visit _____

Patient's Signature _____ Date _____ Dentist's Signature _____ Date _____

Or Parent if Minor

I certify that answers given on this patient registration / health / dental history are true and complete to the best of my knowledge.