



### Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
If minor Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Pharmacy you prefer: \_\_\_\_\_ Location: \_\_\_\_\_  
Referring Dentist: \_\_\_\_\_ Office: \_\_\_\_\_

### Patient Dental History

General Dentist (If same as referring dentist you can leave blank): \_\_\_\_\_

Date of last cleaning: \_\_\_\_\_ How often do you brush: \_\_\_\_\_

**\*\*\*The following questions must be circled individually. Please circle one\*\*\***

- |                                    |           |                                   |           |
|------------------------------------|-----------|-----------------------------------|-----------|
| -Do your jaw joints click or pop?  | YES or NO | -Do you have pain in your jaw?    | YES or NO |
| -Do you grind your teeth?          | YES or NO | -Do you have headaches regularly? | YES or NO |
| -Do you have any loose teeth?      | YES or NO | -Have you had Orthodontic         |           |
| -Do you clench during the day?     | YES or NO | Treatment?                        | YES or NO |
| -Do your gums bleed when           |           | -Do you have bad breath or a      |           |
| you floss or brush?                | YES or NO | bad taste?                        | YES or NO |
| -Do you often have fever blisters? | YES or NO | -Have you had Periodontal         |           |
| -Has anyone in your family lost    |           | Treatment?                        | YES or NO |
| all their teeth?                   | YES or NO | -Alcohol use? How much? _____     | YES or NO |
| -Any tobacco use currently or in   |           |                                   |           |
| the past? How much? _____          | YES or NO |                                   |           |

## Medical History

Medical Doctors Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Reason: \_\_\_\_\_

Are you currently receiving any medical treatment? YES or NO

Reason: \_\_\_\_\_

Are you taking any medications regularly? YES or NO

Which ones: \_\_\_\_\_

Do you require premedication (antibiotics) for any reason? YES or NO

Reason: \_\_\_\_\_

\*\*\*\*\*Do you now, or in the past, had any of the following:

-Anemia	YES or NO	-Arthritis	YES or NO
-Bladder Problems	YES or NO	-Kidney Problems	YES or NO
-Bleeding	YES or NO	-Clotting Problems	YES or NO
-Liver Problems	YES or NO	-Low Blood Pressure	YES or NO
-Diabetes	YES or NO	-Recent Surgery	YES or NO
-Osteoporosis	YES or NO	-Gastric Ulcer	YES or NO
-Excessive Thirst	YES or NO	-Thyroid Problems	YES or NO
-Venereal Disease	YES or NO	-Hepatitis	YES or NO
-High Blood Pressure	YES or NO	-Family Diabetes	YES or NO
-Lung Problems	YES or NO	-Rheumatic Fever	YES or NO
-Heart Conditions	YES or NO	-Glandular Problems	YES or NO
-Psychiatric Problems	YES or NO	-Substance Abuse	YES or NO
-Aids	YES or NO	-Artificial Joints	YES or NO
-Pacemaker/Stent	YES or NO		

IF YES TO ANY, REASON: \_\_\_\_\_

Have you ever taken Cortisone? YES or NO When and how long? \_\_\_\_\_

Have you ever taken Anticoagulants? YES or NO When and how long? \_\_\_\_\_

Do you take Aspirin daily? YES or NO Dosage? \_\_\_\_\_

Do you take a Bisphosphanate drug? YES or NO How long? \_\_\_\_\_

Do you tire easily? YES or NO When? \_\_\_\_\_

Do you bruise easily? YES or NO Does it linger? \_\_\_\_\_

Do you consider your health good? YES or NO I no, explain: \_\_\_\_\_

Do you take daily vitamins? YES or NO Females-Menopause? YES or NO

\*\*\*\*\*Are you now or have you ever been ALLERGIC to any of the following medications?

-Aspirin YES or NO -Antihistamines YES or NO

-Barbiturates YES or NO -Codeine YES or NO

-Demerol YES or NO -Novocaine YES or NO

-Penicillin YES or NO -Latex YES or NO

-Antibiotics YES or NO If yes, which Antibiotics? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

