Welcome To Our Practice

Chart #:____________

Patient Name:____Date:_________________
Last First MI

Dental Information

Date of last dental visit: ________________ Reason for that visit: _________________________________

Y N Are you in pain today?
Y N Are your teeth sensitive to:
Hot? Cold? Pressure? Sweets?
Y N Are you fearful about dental treatment?

Y N Do you clench / grind your teeth?
Y N Have you ever seen a dental specialist?
Y N Would you like to be sedated?
Y N Would you like whiter teeth?
Y N Would you like straighter teeth?

Health History

Y N Are you in good health?
Who is your MD?
Name: ______________________________
Phone Number: (______) ________________
How long since your last exam? _____________

Are you taking any prescription or over-the-counter (OTC) medications? Please list:
____
____
____
____

Y N Have you ever been Hospitalized?
Why? _______________________________
Y N Do you have "Dry Mouth"
Y N Have you ever been diagnosed with a sleep disorder or Sleep APNEA?
Y N Do you use a CPAP Machine?

Are you allergic to any of the following drugs?

Penicillin	Tetracycline	Dental Anesthetics
Aspirin	Latex	Erythromycin
Codeine	Sulfa Drugs	Other: __________
Sedatives	Jewelry / Metals ______________	

For Woman

Y N Are you taking birth control pills?
Y N Is it possible you could be pregnant?
Y N Are you nursing?

Please answer yes or no to each of the following that you have ever had or been treated for:

Y N AIDS / HIV
Y N Allergies
Y N Artificial Joints / Surgical Implant
Y N Asthma / Hay Fever / Respiratory Problems
Y N Autoimmune Disorders
Y N Cancer
Y N Diabetes
Y N Epilepsy / Seizures / Fainting Spells / Dizziness
Y N Excessive Bleeding or Blood Disorders
Y N Glaucoma
Y N Head Injuries
Y N Heart Attack / Stroke Date: ____/____/_______
Y N Heart Disorders
Y N Heart Murmur / Mitral Valve Prolapse
Y N Hepatitis A B C
Y N High Cholesterol
Y N High Blood Pressure ________/________
Y N Kidney Disease
Y N Liver Disease
Y N Mental / Psychiatric Disorders / Dementia
Y N Nerve Disorders, Cerebral Palsy, MS
Y N Osteoporosis or take Bisphosphonate Medication
Y N Pacemaker or Stents Date: ____/____/________
Y N Prosthetic Valves
Y N Radiation Treatment / Chemotherapy
Y N Steroid Therapy
Y N Tuberculosis
Y N Thyroid Disease

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

_______________________________________ _________________
Signature of Responsible Party *Date*

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the CDA