General Information

Name (First and last):_____ Date of birth: _____
Emergency contact: Name: _____ Phone number: _____Relationship:_____

Medical History

Doctor Name: _____ Phone Number: _____

Do you require antibiotic premedication for your dental appointment? Yes or No
If yes, what antibiotic regiment and why?_____

Do you use any tobacco? Yes or No
If yes, what type and how often?_____

Do you have or ever had any of the following medical conditions: (Please circle one)

Abnormal bleeding...Yes or No
Arthritis...Yes or No
Asthma...Yes or No
Cancer...Yes or No - If yes, explain:_____
Diabetes...Yes or No - If yes, type:_____
Epilepsy...Yes or No - If yes, explain:_____
Fainting Spells...Yes or No - If yes, explain:_____
Glaucoma...Yes or No
Heart Condition...Yes or No - If yes, explain:_____
Heart Murmur...Yes or No
Hepatitis...Yes or No - If yes, type:_____
High Blood Pressure...Yes or No
HIV/AIDS...Yes or No
Joint Replacement...Yes or No - If yes, when and type:___
Kidney Problems...Yes or No
Mental Disability...Yes or No - If yes, explain:_____
Liver Problems...Yes or No
Pacemaker...Yes or No
Psychiatric Treatment...Yes or No - If yes, reason:_____
Rheumatic Fever...Yes or No
Seizures...Yes or No - If yes, explain: _____
Sinus Trouble...Yes or No
Stroke...Yes or No - If yes, type and when: _____
Thyroid condition...Yes or No
Ulcers... Yes or No
Other condition not listed above:_____

Are you taking or scheduled to begin taking bisphosphonate medication such as; Fosamax (Alendronate), Actonel (Risedronate), or Bonvia (Ibandronate)? Yes or No

Please list all medications you are taking:

_____

_____

Are you allergic to any of the following?

Anesthetic...Yes or No
Aspirin...Yes or No
Codeine...Yes or No
Ibuprofen...Yes or No
Iodine...Yes or No
Latex...Yes or No
Penicillin...Yes or No
Sulfa...Yes or No
Other:_____

Dental History

Former Dentist (Name and Location):_____
Last cleaning/exam:_____ Last Panoramic/FMX x-rays:_____ Last Bitewing x-ray:_____
Reason for Visit:_____ Are you in pain (if yes explain):_____

Any unusual reactions to dental injections (If yes, explain):_____
Condition of your teeth and gums(Please circle one)? Good Fair Poor
How often do you brush your teeth?_____
How often do you floss you teeth?_____
Do you clench or grind your teeth? Yes or No
Any other dental conditions not mentioned above?_____

Patient or Guardian Signature:_____ Date:_____