OFFICE USE ONLY: Acct. # _____

Health Information

We take your oral health very seriously. But before we start your treatment, we need some brief information on your medical history which may affect your treatment. All information is confidential.

Patient's Name: _____ Date of Birth: _____ Last Physical Date: _____

Physician's Name & Phone #: _____ Reason for today's visit? _____

Work Related Injury? (circle) **Yes** **No** Have you been under the care of a physician? (circle) **Yes** **No**

Have you ever been hospitalized? (circle) **Yes** **No**

Height: _____ Weight: _____

Date of last dental visit: _____ Date of last dental x-rays: _____ Date of last cleaning: _____

Have you ever been treated for periodontal (gum) disease? (circle) **Yes** **No**

Ever had Novocaine or other local anesthetic? (circle) **Yes** **No**

Are you interested in tooth whitening? (circle) **Yes** **No**

If wearing dentures, age of dentures: _____ Are you interested in new dentures? (circle) **Yes** **No**

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? (circle) **Yes** **No**

Are you taking or have taken Oral Bisphosphonates?(e.g., FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates, (e.g., ZOMETA, AREDIA) (circle) **Yes** **No** Taken for how long? _____

Have you taken antibiotics prior to dental procedures in the past? (circle) **Yes** **No**

Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle) **Yes** **No**

List any medications you are allergic to:

1. _____ 2. _____ 3. _____ 4. _____

List any medications you are taking including non-prescription drugs and herbals/vitamins:

1. _____ 2. _____ 3. _____ 4. _____

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Thyroid Disease			Alcoholism		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Fainting or Dizzy Spells			Mouth sores/growths		
Diabetes			Teeth Grinding/Clenching			Pace Maker/Heart Surgery			Aspirin/Anticoagulant Therapy		
Venereal Disease			Arthritis			Pain in your jaw (TMJ)			Ulcers or Stomach Problems		
High Blood Pressure			HIV Positive/AIDS			Latex Allergy			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Cancer (Type:)		
Any type of Transplant			Heart Problem ( )			Excessive Bleeding			Any Artificial Hip, Knee or other Joint		
Drug Addiction			Dialysis			Stroke			Other Disease or Illness:		
Hepatitis (Type:)			Chemotherapy			Lung Disease					
Liver Disease			Radiation Treatment			Breathing Problems					
Kidney Disease			Use of Tobacco Products			Tuberculosis (TB)					

Women patients only:	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated Delivery Date: / /			Are you taking any birth control prescriptions?		

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature _____ Date _____ Dr's. Signature/Medical History Review _____ Date _____

6 MONTH UPDATE → Patient's Signature _____ Date _____ Dr's. Signature/Medical History Review _____ Date _____