



PATIENT NAME(as it appears on your ID) _____

NICKNAME/ PREFERRED NAME _____

So that we may provide you with the best possible care, please complete the medical/dental history form - Thank-you.

What is the reason for your visit today? _____

Former Dentist _____ Why did you leave your last dentist? _____

Date of Last Dental Visit _____ X-rays _____ Cleaning _____

How often do you have dental examinations? _____ Cleanings _____

How often do you brush your teeth? _____ How often do you floss? _____

Are you under the care of a Physician? _____ If so, what for? _____

Name, address and phone number of that Physician _____

Any Hospitalizations in the past 5 years? _____ If so, what for? _____

Do you require antibiotics prior to dental treatment? _____ If so, what do you take? _____

Do you have a history of Cancer? _____ If yes, how long ago? _____ Are you in remission? _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? If yes please list _____

Are you allergic to **LATEX**? YES _____ NO _____

ARE YOU TAKING ANY MEDICATIONS? If yes please list _____

Are you taking any Anticoagulants (blood thinners)? _____ If yes, please list _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? _____ If yes, please list _____

Are you on any oral or injectable medication for **Osteoporosis**? _____ If yes, please list _____

FOR WOMEN: Are you pregnant? If so, what is your due date? _____

Are you currently nursing? YES or NO

Medical History and information

Are your teeth sensitive to: YES NO

Heat/Cold _____
Sweets? _____
Biting Pressure? _____
Do your gums bleed when brushing? _____
Have you noticed any gum swelling around any teeth? _____
Do you have an unpleasant taste or odor in your mouth? _____

Problems of the Jaw:

Clicking of the jaw _____
Pain (joints, ear, side of face) _____
Difficulty opening or closing _____
Difficulty chewing _____
Do you wear retainers or a night guard? _____
Do you ever avoid any part of the mouth while brushing? _____
Have you had a reaction to a local anesthetic? _____
Are you dissatisfied with your teeth and their appearance? _____
Are you deeply concerned about the finances required to achieve excellent dental health? _____
Do you use tobacco in any form? _____
If yes, please list _____
Do you use recreational drugs? _____

Do you have any dental related fears? _____
Do you frequently get cold sores, blisters, or any other oral lesions? _____
Do you snore? Yes _____ No _____

Have you ever been diagnosed with sleep apnea? _____
If yes, are you using CPAP or Oral Appliance? _____

Do you currently or have you ever had the following conditions?

YES NO
 _____ Heart Ailment/Murmur _____
 _____ Coronary artery disease/Heart attack/ Stents _____
 _____ Stroke _____
 _____ Blood Thinners(please list medication above) _____
 _____ Allergies. Please list _____
 _____ Artificial bones/ joints/ valves _____
 _____ Asthma _____
 _____ Arthritis _____
 _____ Pacemaker _____
 _____ Cancer _____
 _____ Diabetes _____
 _____ Dizziness/Fainting _____
 _____ Acid Reflux _____
 _____ Epilepsy/ Seizures _____
 _____ Prolonged Bleeding _____
 _____ Healing Complications _____
 _____ Hepatitis _____
 _____ High Blood Pressure _____
 _____ HIV+ / AIDS _____
 _____ Liver/Kidney Disease _____
 _____ Osteoporosis / Injections? YES _____ NO _____
 _____ Radiation/Chemo treatment When? _____
 _____ Respiratory Problems _____
 _____ Sinus Problems _____
 _____ Thyroid Issues _____
 _____ Ulcers _____
 _____ Tuberculosis _____
 _____ Mental Health Disorders Please Specify: _____



Additional Information

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? **YES or NO**

If yes, please list _____

Is there anything important about your medical condition we have not asked? **YES or NO**

If yes, please describe _____

The most important concerns regarding my dental treatment are: _____

What factors are most important for your satisfaction with our office? _____

Any additional concerns/comments? _____

Child/ Minor Patients: Please answer the following questions:

YES OR NO

_____ Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

_____ Any unusual speech habits? if yes, please explain: _____

_____ Does the patient receive assistance with brushing and flossing? If yes, how often? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in my medical status.

SIGNATURE OF PATIENT, PARENT, or Guardian _____

DATE _____