DENTAL HISTORY

Patient Name_____ Date_____
Date of Birth_____ Reason for today's visit _____

NEW PATIENTS ONLY
Former Dentist _____ Address_____ Date of last dental visit _____

Circle conditions of concern.

TEETH	**GUMS**	**JAW**
Loose teeth or fillings	Bleeding	Grinding/clenching
Sensitive to hot/cold/biting	Bad breath	Pain, chewing
Food collecting between teeth	Sores in mouth	Clicking or popping in joint
	Previous Periodontal treatment	

Is there anything you would change in appearance of teeth or smile?_____

MEDICAL HISTORY

Physician Name _____ Date of last visit _____

MEDICATION ALERT

Do you need to take an **antibiotic** before dental appointments? YES NO
If so, which antibiotic _____
Joint Replacement? YES NO
If so, what joints _____
Heart Valve Replacement? YES NO

Are you taking medicine for Osteoporosis? YES NO
Which one: **Fosamax, Actonel or Boniva**

Are you taking a blood thinner? YES NO
Which one: **Coumadin (Warfarin), Plavix, Pradaxa**

Drug Allergies **LATEX Allergy**
List Any _____
_____
_____

WOMEN: Are you **pregnant**? YES NO **Nursing**? YES NO Taking **birth control pills**? YES NO

Circle if you have had or been treated for any of the following:

Heart Problems	Cancer	Hepatitis	Epilepsy
Rheumatic Fever	Chemotherapy	Tuberculosis	Anxiety
Heart Murmur	Radiation Treatment	Liver Disease	Fainting
Mitral Valve Prolapse	Tobacco Habit	Kidney Disease	Migrane Headaches
Pacemaker	Diabetes	High Blood Pressure	Stroke
AIDS, HIV, STD	Asthma	Back Problems	Thyroid
Arthritis	Chemical Dependency		

MEDICATIONS

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pharmacy Name _____ Patient Signature_____