

Today's Date:



As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:			Home Phone: II	nclude area code	Business/Cell Phon	e: Include area code		
Last	First	Middle	()		()			
Address:			City:		State:	Zip:		
Mailing address								
Occupation:			Height:	Weight:	Date of birth:	Sex: M F		
SS# or Patient ID:	Emergency Cont	act:	Relationship:		Home Phone:	Cell Phone:		
					() Include area code	()		
If you are completing this form for another person, what is your relationship to that person?								
Your Name			Relationship					
Do you have any of the following diseases or problems:			(Check D	K if you Don't l	Know the answer to the q	uestion) Yes No DK		
Active Tuberculosis						🗆 🗆 🗆		
Persistent cough greater than a	3 week duration							
Cough that produces blood						🗆 🗆 🗆		
Been exposed to anyone with the	uberculosis							

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information For the following questions, please mark (X) your responses to the following questions.

Yes No DK	Yes No DK	
Do your gums bleed when you brush or floss?	Do you have earaches or neck pains?	
Are your teeth sensitive to cold, hot, sweets or pressure? \Box \Box	Do you have any clicking, popping or discomfort in the jaw? \Box \Box	
Does food or floss catch between your teeth? \Box \Box	Do you brux or grind your teeth?	
Is your mouth dry? \Box \Box	Do you have sores or ulcers in your mouth?	
Have you had any periodontal (gum) treatments?	Do you wear dentures or partials?	
Have you ever had orthodontic (braces) treatment?	Do you participate in active recreational activities? \Box \Box	
Have you had any problems associated with previous dental	Have you ever had a serious injury to your head or mouth? \Box \Box	
treatment?	Date of your last dental exam:	
Is your home water supply fluoridated?	What was done at that time?	
Do you drink bottled or filtered water?		
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY	Date of last dental x-rays:	
Are you currently experiencing dental pain or discomfort?		
What is the reason for your dental visit today?		

How do you feel about your smile?

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes No DK	Yes	No	DK
Are you now under the care of a physician?	□ □ □	Have you had a serious illness, operation or been		
Physician Name:	Phone: Include area code	hospitalized in the past 5 years? \Box		
	()	If yes, what was the illness or problem?		
Address/City/State/Zip:				
		Are you taking or have you recently taken any prescription		
Are you in good health?		or over the counter medicine(s)?		
Has there been any change in your general health within		If so, please list all, including vitamins, natural or herbal preparations		
the past year?	🗆 🗆 🗆	and/or diet supplements:		
If yes, what condition is being treated?				
Date of last physical exam:				

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question) Do you wear contact lenses?		No	DK	Yes No Do you use controlled substances (drugs)? □ □	ВК		
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?				Do you use tobacco (smoking, snuff, chew, bidis)?			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?				Do you drink alcoholic beverages?			
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates	. 🗆			WOMEN ONLY Are you: Pregnant?			
(Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	. 🗆			Number of weeks:			
Date Treatment began:							
Allergies - Are you allergic to or have you had a reaction to:	Yes	No	DK		DK		
To all yes responses, specify type of reaction.				Metals Image: Constraint of the second se			
Local anestheticsAspirin				Latex (rubber) 🗌 🗌 lodine 🔲 🗌			
Penicillin or other antibiotics				Hay fever/seasonal			
Barbiturates, sedatives, or sleeping pills				Animals			
Sulfa drugs				Food			
Codeine or other narcotics				Other 🗆 🗆			
Please mark (X) your response to indicate if you have or have not	t had	lan	y of				
		No		Yes No DK Yes No	DK		
Artificial (prosthetic) heart valve				Autoimmune disease			
Previous infective endocarditis				Rheumatoid arthritis Image: Construction of the second s			
Damaged valves in transplanted heart				Systemic lupus erythematosus.			
Congenital heart disease (CHD)				Asthma			
Unrepaired, cyanotic CHD	🗆			Bronchitis			
Repaired (completely) in last 6 months				Emphysema			
Repaired CHD with residual defects	🗆			Sinus trouble			
Except for the conditions listed above, antibiotic prophylaxis is no longer reco	omme	endec	d	Tuberculosis Image: Construction of the second se			
for any other form of CHD.				Cancer/Chemotherapy/ Specify: Radiation Treatment			
Yes No DK			DK	Chest pain upon exertion			
Cardiovascular disease C Cardiovascular disease				Chronic pain			
Angina				Diabetes Type I or II			
Arteriosclerosis				Eating disorder			
Congestive heart failure				Malnutrition			
Damaged heart valves Image: Abnormal bleeding Heart attack Image: Anemia				Gastrointestinal disease			
Heart murmur				heartburn			
Low blood pressure				Ulcers Image: Severe or rapid weight loss			
High blood pressure							
				Stroke			
defects							
Has a physician or previous dentist recommended that you take ant	ihiot	ics n	rior	to your dental treatment?			
		.c. p					
Name of physician or dentist making recommendation:				Phone:			
Do you have any disease, condition, or problem not listed above that you think I should know about?							
NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.							
Signature of Patient/Legal Guardian:				Date:			
			-				
	CO	VIPL	EII	ON BY DENTIST			
Comments:							
					-		