

EMERGENCY INFORMATION

Name of nearest relative not living with you _____
Last First Middle

Address _____
Street City State Zip Emergency Phone #

PATIENT DENTAL HISTORY

Date of Last Dental Exam: _____ Date of Last Dental X-Rays _____
Chief Oral Complaint _____

(It is your responsibility to inform the Dental Assistant of Previously taken x-rays)

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Physician's Address _____
Street City State Zip Physician's Phone #

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING-INDICATE WITH A (✓)

- | | | |
|--|---|--|
| <input type="checkbox"/> Teeth sensitive to cold, heat, sweets or pressure | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Cigarettes, pipe or cigar smoking |
| <input type="checkbox"/> Bleeding gums, How long? _____ | <input type="checkbox"/> Unpleasant taste | <input type="checkbox"/> Texture of toothbrush _____ |
| <input type="checkbox"/> Food impaction | <input type="checkbox"/> Unfavorable dental experience | <input type="checkbox"/> Frequency of brushing _____ |
| <input type="checkbox"/> Clenching or grinding | <input type="checkbox"/> Complications from extraction | <input type="checkbox"/> Dental Floss |
| <input type="checkbox"/> Burning of tongue | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Inter dental stimulators |
| <input type="checkbox"/> Swelling or lumps in mouth | <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Water jet device |
| <input type="checkbox"/> Frequent blisters on lips or mouth | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Disclosing tablets or solution |
| <input type="checkbox"/> Pain around ear | <input type="checkbox"/> Oral Habits, i.e., fingernail biting, cheek biting, etc. | <input type="checkbox"/> Fluoride supplements |
| <input type="checkbox"/> Unusual sounds in ear while eating | | |

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING- INDICATE WITH A (✓)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Special Needs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| | | | <input type="checkbox"/> Venereal Disease |

Have you had any serious illnesses? If yes, describe _____

Have you had any operations or transplants? If yes, describe _____

Have you ever had a blood transfusion? If yes, give approximate dates _____

(Women) Are you pregnant? Yes No **(Women) Are you taking birth control pills?** Yes No

Please list all medications that you are currently taking or have taken recently

ALLERGIES

- | | | |
|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Codeine | _____ |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Penicillin | _____ |
| <input type="checkbox"/> LATEX | <input type="checkbox"/> ERYTHROMYCIN | _____ |

Signature of Patient or Responsible Party _____

Date _____