Welcome To Our Practice

Chart #:_____

Patient Name:_____Date:_____
Last First MI

Dental Information

Date of last dental visit: _____ Reason for that visit: _____

Y N Are you in pain today?
Y N Are your teeth sensitive to:
☐Hot?☐Cold?☐Pressure?☐Sweets?
Y N Are you fearful about dental treatment?
Y N Do you clench/grind your teeth?
Y N Have you ever seen a dental specialist?
Y N Would you like to be sedated?
Y N Would you like whiter teeth?
Y N Would you like straighter teeth?

Health History

Y N Are you in good health?

Who is your MD?
Name: _____
Phone Number: (_____)_____

How long since you last exam? _____

Are you taking any prescription or over-the-counter (OTC) medications? Please list:
_____
_____
_____
_____

Y N Have you ever been Hospitalized?
Why? _____
_____

Y N Have you ever had abnormal bleeding following any surgical procedure?

Are you allergic to any of the following drugs?
☐Penicillin☐Tetracycline☐Dental Anesthetics
☐Aspirin ☐Latex ☐Erythromycin
☐Codeine ☐Sulfa Drugs ☐Other: _____
☐Sedatives☐Jewelry/Metals _____

For Woman

Y N Are you taking birth control pills?
Y N Is it possible you could be pregnant?
Y N Are you nursing?

Please answer yes or no to each of the following that you have ever had or been treated for:

Y N AIDS/HIV
Y N Allergies
Y N Anemia
Y N Artificial Joints / Surgical Implant
Y N Asthma / Hay Fever / Respiratory Problems
Y N Cancer
Y N Diabetes
Y N Epilepsy / Seizures / Fainting Spells / Dizziness
Y N Excessive Bleeding
Y N Glaucoma
Y N Head Injuries
Y N Heart Attack / Stroke Date: _____
Y N Heart Disease
Y N Heart Murmur / Mitral Valve Prolapse
Y N Hepatitis ☐A ☐B ☐C
Y N High Cholesterol
Y N High Blood Pressure _____/_____
Y N Kidney Disease
Y N Liver Disease
Y N Mental / Psychiatric Disorders
Y N Osteoporosis
Y N Pacemaker
Y N Phen-fen
Y N Prosthetic Valves
Y N Radiation Treatment / Chemotherapy
Y N Steroid Therapy
Y N Tuberculosis
Y N Thyroid Disease

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

_____ _____
Signature of Responsible Party *Date*

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the CDA