Rockton Dental Care **Health Information**

Name:_____ Date of Birth:_____

Have you ever had or do you now have any of the following? Please check those that apply:

[] Allergies_____
_____
[] Heart Trouble
[] Low Blood Pressure
[] High Blood Pressure
[] Heart Murmur
[] Mitral Valve Problems
[] Implants (valve, hip, etc)
[] Stroke
[] Sexually transmitted disease
[] Hepatitis
[] Diabetes
[] Nervous Disorders
[] Radiation Treatment
[] Chemo Therapy
[] Cancer
[] Tuberculosis
[] Epilepsy
[] HIV +Test (AIDS Virus)
[] Chemical Dependency
[] Asthma
[] Pacemaker
[] Bleeding Disorder
[] Anemia
[] Kidney or Liver disease
[] Reaction to Metal Jewelry
[] Ulcers
[] Drug Reaction/ Allergy
_____
_____
[] Rheumatic or Scarlet Fever

Females: Are you Pregnant [] Yes [] No Due date:_____

Would you like whiter teeth? [] Yes [] No Are any of your teeth overly sensitive? [] Yes [] No

Would you like straighter teeth? [] Yes [] No Have you ever considered braces? [] Yes []No

If you could change one thing about your smile, what would it be?_____

_____

Are you bothered by frequent cold/canker sores? [] Yes [] No

Are you in good health? [] Yes [] No
Are you currently taking any medication(s) including aspirin / herbal? [] Yes [] No if yes, list all medications:_____
_____
_____
Have you been admitted to a hospital or needed emergency care during the past two years? [] Yes [] No
If yes please explain:_____
Are you now under the care of a physician? [] Yes [] No if yes, please explain: _____
_____
Name of Physician: _____Phone:_____
Do you have any health problems that need further clarification? []Yes []No If yes, Please explain:_____
_____
To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform Rockton Dental Care at the next appointment without fail.
X_____Date:_____
Signature of patient, parent or guardian

Referral information

Whom may we thank for referring you to our practice? [] Another patient [] Dental Office [] Website [] Yellow pages
[] Newspaper [] School [] Work []Other_____
Name of person or office referring you to our practice: _____

Dental History

Name of former Dentist: _____
Reason for changing: _____