Whom may we thank for referring you to our office?_____

How did you hear about our office? _____

Names of other family members seen by us_____

Dentist Name :_____ Phone # _____

Address _____ City_____ State_____ Zip Code_____

When was the last dental cleaning?_____ Is there any dental work currently recommended by your dentist? Y N

Do you go every 6 months for cleanings? Yes or No

Health History

Is the patient currently in any pain? Y N

Has the patient ever had a serious or difficult problem with dental work? Y N

Is there any pain or tenderness currently or in the past in the jaw joint area? Y N

Do you brush your teeth daily? Y N How many times a day? _____ Do you floss daily? Y N

What type of bristles do you use? Soft Medium Hard Do your gums ever bleed? Y N

Do you have a personal physician? Y N Name: _____ Phone # _____

Current physical health: Poor Fair Good Is the patient currently under the physician's care? Y N

Please list all medication the patient is currently taking:_____

Circle any of the medical conditions below that the patient has had or currently has:

Heart Murmur	Cancer	Diabetes	Rheumatic Fever
Hemophilia	Asthma	Hepatitis	Tuberculosis
Congenital Heart Defect	Abnormal Bleeding	Hearing Impaired	Kidney/Liver Problems
Handicaps/Disabilities	Drug allergies	Scarlet Fever	Shingles
Fever Blisters	Venereal Disease	Ulcers/Colitis	Emphysema
Convulsions/Epilepsy	Artificial Valves	Heart Attack	Sinus Problems
Difficulty Breathing	Anemia	Radiation Treatment	Blood Transfusion
Drug/Alcohol abuse	High/Lo Blood Pressure	HIV/Aids	Severe/Frequent headaches
Mitral Valve Prolapse	Heart Surgery/Pacemaker	Glaucoma	Any stays in the hospital

Does the patient have any of the following habits: Thumb or finger sucking? Y N Lip biting or sucking? Y N
Nail biting? Y N Nursing bottle habit? Y N

Is the patient allergic to any of the following? Aspirin Y N Codeine Y N Latex Y N Penicillin Y N Other_____

For females only: Have you started your menstruation cycle? Y N At what age? _____
Do you take birth control pills? Y N Are you pregnant? Y N Are you nursing? Y N

I understand the information that I have given is correct to the best of my knowledge, that 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 also authorize Dental staff to perform the necessary dental services I may need during treatment.

Signature _____Date _____

For Office Use Only:

I have verbally reviewed the medical and dental information above with the patient/parent/guardian.
Doctor's signature _____Date _____
Comments: _____

Medical history updated: Date_____Signature _____ Changes in medical history? Y N
Doctor's signature _____Date_____

Medical history updated: Date_____Signature _____ Changes in medical history? Y N
Doctor's signature _____Date_____