

Dental Information

Reason for Today's Visit _____

Former Dentist _____ Address _____

Date of Last Dental Exam _____ Date of Last Dental X-rays _____

Unfinished dental treatment? If yes, please explain: _____

Is there anything you would like to change about your teeth? _____

How often do you brush/floss your teeth? _____

Do you use tobacco products? _____ How often? _____ Have you had orthodontics (braces)? _____

Is there anything else you would like us to know so that we can best meet your needs? For example: anxiety concerns, previous negative experiences, etc. _____

Health Information

Do you have any CURRENT HEALTH PROBLEMS (for example: diabetes, high blood pressure, respiratory disease, infections, H.I.V., hepatitis, etc.) If yes, please explain. _____

Have you had any major health problems in the past? If yes, please explain. _____

When was your last physician visit? _____

FAMILY PHYSICIAN'S NAME, CLINIC, and PHONE _____

What prescription and over-the-counter MEDICATIONS are you currently taking? Please list.

Have you ever taken Fosamax or other bisphosphonates? _____

Do you have a history of infective endocarditis? _____

Do you have a congenital heart condition? If yes, please explain. _____

Have you ever had any heart problems? If yes, please explain. _____

Do you have any ALLERGIES? If yes, to what? _____

Women, are you pregnant? How many months? _____

Please inform the dentist of any changes to your health history and/or medications, as this may impact your dental care and general health.

Patient's signature: _____ Date: _____