DENTAL HEALTH

Your current dental health is: Excellent Good Fair Poor Are you pleased with your smile? Yes No

If No, what would you change if you could? _____

Do your gums ever bleed? Yes No If yes, when? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

What kind of toothbrush do you use? Manual Electric

Have you ever had treatment for periodontal disease including gum surgery, scaling and root planing (deep cleaning) or other gum treatment? Yes No

Have you ever seen a gum specialist (Periodontist)? Yes No

MEDICAL HISTORY

Do you have any of the following?: (circle all that apply)

Congenital Heart Defect, Artificial Heart Valve, Infective Endocarditis, Cardiac Transplant, Artificial Joint Replacement

If yes to the above question, what antibiotics has your Cardiologist/Orthopedic Surgeon recommended for you to take prior to your dental visits? _____

Do you smoke? Yes No How many packs a day? _____ For how many years? _____

Do you use smokeless tobacco? Yes No Do you have diabetes? Yes No

Are you allergic to: Latex _____ Codeine _____ Antibiotics (list) _____

_____

Do you have any other allergies? _____

Are you taking any prescription or over the counter medications? Yes No

Please list: _____

_____

_____

FOR WOMEN: Are you pregnant? Yes No Nursing? Yes No

Are you taking birth control pills? Yes No

MEDICAL CHECKLIST

Do you have or ever experienced any of the following?

- ❑ Arthritis
- ❑ AIDS/HIV+
- ❑ Cancer: Location _____
- ❑ Difficulty Breathing
- ❑ Emphysema / Asthma
- ❑ Drug / Alcohol Concerns
- ❑ Angina / Chest Pain
- ❑ Epilepsy / Seizures
- ❑ Fainting Spells
- ❑ Fever Blisters / Herpes
- ❑ Heart Attack
- ❑ Heart Surgery/Pacemaker
- ❑ Hemophelia / Anemia
- ❑ Hepatitis / Liver Problems
- ❑ High / Low Blood Pressure
- ❑ Kidney Problems
- ❑ Severe/Frequent Headaches
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Sexually Transmitted Disease
- ❑ Ulcer / Colitis

Primary Physician's Name _____

Address _____ City _____

State _____ Zip _____ Phone: (_____) _____

Specialist Names (Cardiologist, Orthopedic Surgeons, Internist, etc.): _____

_____

Address _____ City _____

State _____ Zip _____ Phone: (_____) _____

I UNDERSTAND

The information I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my personal or medical status. I authorize the dental personnel to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. If the patient is a minor I certify that I am the legal guardian.

_____

Responsible Party (Must be 18 years or older) Date