

NAME/MS. _____ DATE ____/____/____
MISS/MR. _____
MRS./DR. _____ SS# ____--____--____

ADDRESS _____
LAST MI FIRST DATE OF BIRTH ____/____/____
STREET CITY/TOWN ZIP

HOME PHONE () _____ CELL () _____ E-MAIL _____

OCCUPATION _____ PLACE OF WORK _____ WORK PHONE () _____

REFERRING DENTIST _____
NAME CITY/TOWN

CONTACT IN CASE OF EMERGENCY _____ RELATIONSHIP _____ PHONE() _____

REASON FOR THIS VISIT _____

CHECK IF YOU HAD BEEN CARED FOR BY ANY OF THE FOLLOWING:

ORTHODONTIST PERIODONTIST ORAL SURGEON OTHER NAME _____

PHYSICIAN'S NAME _____ PHONE () _____

ARE YOU NOW OR HAVE YOU RECENTLY BEEN UNDER A PHYSICIAN'S CARE? Y / N

IF YES, FOR WHAT REASON _____

CHECK IF YOU ARE ON ANY OF THE FOLLOWING MEDICATION:

STEROID SYNTHROID COUMADIN PLAVIX ASPIRIN

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, IF ANY _____

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

- | | | |
|-----------------------------------------------|--------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> CONGENITAL HEART DEFECT | <input type="checkbox"/> HERPES |
| <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> HIV |
| <input type="checkbox"/> ASTHMA / HAY FEVER | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> SINUS PROBLEM | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> DIZZY SPELLS / SEIZURES |
| <input type="checkbox"/> EAR INFECTION | <input type="checkbox"/> ARTIFICIAL VALVE | <input type="checkbox"/> EPILEPSY |
| <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> PACE MAKER | <input type="checkbox"/> NEUROLOGICAL DISORDER |
| <input type="checkbox"/> LUNG DISEASE | <input type="checkbox"/> IRREGULAR HEARTBEAT | <input type="checkbox"/> GLAUCOMA |
| <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> HEART ATTACK WHEN _____ | <input type="checkbox"/> DRUG OR ALCOHOL ADDICTION |
| <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> HEART SURGERY | <input type="checkbox"/> PSYCHIATRIC TREATMENT |
| <input type="checkbox"/> HEPATITIS / JAUNDICE | <input type="checkbox"/> ABNORMAL BLEEDING | <input type="checkbox"/> CANCER _____ |
| <input type="checkbox"/> SLOW HEALING | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> CHEMOTHERAPY |
| <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> RADIATION THERAPY |
| <input type="checkbox"/> STOMACH ULCERS | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> MAJOR OPERATION _____ |
| <input type="checkbox"/> THYROID DISEASE | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> PROSTHETIC JOINTS WHEN _____ |
| <input type="checkbox"/> OTHER _____ | | |

CHECK IF YOU HAVE HAD SENSITIVITY OR ALLERGIC RESPONSE TO ANY OF THE FOLLOWING:

LOCAL ANESTHETICS EPINEPHRINE ASPIRIN CODEINE
 LATEX IODINE ANTIBIOTICS _____
 OTHERS _____

HAVE YOU EVER TAKEN ANTIBIOTICS BEFORE DENTAL PROCEDURES? Y / N NAME _____

DO YOU SMOKE TOBACCO? Y / N IF YES, HOW MUCH? _____

WOMEN ONLY: ARE YOU PREGNANT? Y / N HOW MANY MONTHS? _____ ARE YOU BREAST FEEDING? Y / N

PLEASE INDICATE ANY SPECIAL CONCERNS RELATED TO YOUR DENTAL TREATMENT _____

I HAVE REVIEWED THE INFORMATION ON THIS QUESTIONNAIRE AND IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____/_____/____ DATE ____/____/____
SIGNATURE OF PATIENT OR PARENT IF PATIENT IS A MINOR OR RESPONSIBLE PARTY RELATIONSHIP TO PATIENT