

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION			
Last Name:	First Name:	Middle Name:	
Home Phone:	Cell Phone:	Work Phone:	
Email Address:			
Mailing Address:	City:	State:	Zip:
Date of Birth: / /	Gender:		
Occupation:			
Emergency Contact: Name:	Relationship:	Phone:	
If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____ If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.			
DENTAL HISTORY & SYMPTOMS			
What is the reason for your visit today?			
Are you currently experiencing any dental pain or discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?			
When was your last dental exam? / /		What was done at that appointment?	
When was the last time you had dental x-rays taken?			
Please mark an "X" in the box ONLY if this applies to you.			
Is it hard to open your mouth? <input type="checkbox"/> Does it hurt to chew, bite or swallow? <input type="checkbox"/> Do your gums bleed when you brush or floss your teeth? <input type="checkbox"/> Have you ever had periodontal (gum) treatments like scaling and root planing? <input type="checkbox"/> Do you have, or have you ever had, any sores or growths in your mouth? <input type="checkbox"/> Do you clench or grind your teeth? <input type="checkbox"/> Does your jaw click, pop or hurt? <input type="checkbox"/> Do you have earaches or neck pains? <input type="checkbox"/> Does dental treatment make you nervous? <input type="checkbox"/> Have you ever experienced any of these sleep-related breathing disorders? <input type="checkbox"/> <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep	Have you ever had a serious injury to your head or mouth? <input type="checkbox"/> If yes, please describe what happened and when it happened: _____ _____ Have you ever had problems with dental treatment in the past? <input type="checkbox"/> If yes, please describe what happened: _____ _____ Have you ever had a reaction to, or problem with, dental anesthesia? <input type="checkbox"/> If yes, please describe what happened: _____ _____ Are you unhappy with your smile? <input type="checkbox"/> If yes, why? Please mark all that apply: <input type="checkbox"/> The color of your teeth <input type="checkbox"/> The shape of your teeth <input type="checkbox"/> The position of your teeth <input type="checkbox"/> Other. Please describe: _____		
MEDICATIONS & OTHER PRODUCTS/SUBSTANCES			
Please use an "X" to mark your answers to the following questions.			Yes No ?
Are you taking any blood thinners (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
If yes, what medication are you taking? _____			
Are you taking any medication to treat osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zoledronate (Reclast®), and denosumab (Prolia®).			
If yes, what medication are you taking? _____			
Are you taking, or scheduled to take, an IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zoledronate (Zometa®).			
If yes, what medication are you taking? _____ How many years have you been taking it? _____			
Are you taking hormonal replacements ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Do you use vaping products ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
How many alcoholic beverages do you have per week? _____			
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
If yes, what substances? _____ If yes, how often is your use? <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally			
Was the substance prescribed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what reason(s)? _____			
Do you take any other prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
If yes, please list them here and include information about how much and how often you use each one. _____			
WOMEN ONLY: Are you:			
Taking birth control pills ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Pregnant? If yes, number of weeks: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Nursing? If yes, number of weeks: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

