FAMILY DENTISTRY INFORMATION

Name: _____ Date: _____

Dental Information: Please (x) mark your responses to the following questions. Check **DK** if you don't know the answer:

	Y	N	DK	TMJ (Jaw Joint)	Y	N	DK
Are you currently experiencing dental pain or discomfort?				Do you have earaches or neck pains?			
Are your teeth sensitive to cold, hot, sweets or pressure?				Do you clench or grind your teeth?			
Have you had any periodontal (gum) treatments?				Do you have any clicking, popping or discomfort in the jaw?			
Have you ever had any orthodontic (braces) treatment?				Do you wear, or have you ever worn, a nighttime bite splint?			
				Date of your last dental exam: What was done at that time?			
Is your mouth dry?				Date of last dental x-rays:			
Is your home on well water?				Do you prefer appointment reminders by ... (mark all that apply) ☐ Mail ☐ Phone ☐ Text message ☐ Email			
Have you had any problems associated with previous dental treatment?				How did you hear about our office?			
Have you ever had a serious injury or surgery to your head or mouth?							
What is the reason for your dental visit today?							
How do you feel about your oral health & appearance?							

Medical Information: Please (x) mark your responses to the following questions. Check **DK** if you don't know the answer:

	Y	N	DK		Y	N	DK
Are you currently under the care of a physician?				Have you had a serious illness, operation or been hospitalized in the past 5 years?			
Physician Name:				If yes, what was the illness or problem:			
Address/City/State/Zip				Date of last physical exam:			
Please list all the prescription/OTC/diet supplements you are taking **AND** the reason you are taking them.							
Do you use tobacco?	Y	N	DK	Were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates (aredia-or "Zometa") for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	Y	N	DK
How much? How long?				Are you taking or scheduled to begin either of the medications, alendronate (Fosmax) or risedronate (Actonel) for osteoporosis or Paget's disease?			
If so, are you interested in quitting?							
Do you drink alcoholic beverages?							
How many drinks do you consume per week?							
Do you use illegal or recreational drugs?							
Joint Replacement – Have you had an orthopedic total joint (hip, knee and/or elbow) replacement? Which joint? _____ Date: _____ Have you had any complications? _____							

Name: _____ Date: _____

Medical Information: Please (x) mark your responses to the following questions. Check **DK** if you don't know the answer:

Allergies: Are you allergic to or have you had a reaction to:								**Women Only** – Are you:	**Y**	**N**	**DK**
	Y	**N**	**DK**		**Y**	**N**	**DK**	Pregnant?			
Penicillin				Sulfa Drugs				Number of Weeks? ____			
Erythromycin				Codeine				Nursing?			
Local Anesthetic				Seasonal				Taking birth control pills or hormonal replacement?			
Latex/Food				Other:				_____			
Please Explain:											

Do you currently have or ever had a history of the following?

	Y	N	DK		Y	N	DK		Y	N	DK		Y	N	DK
Heart Murmur				Asthma				Acid Reflux				Autoimmune Disease			
Rheumatic Fever				Bronchitis				Ulcers				Arthritis			
Artificial heart valves				Emphysema				Hepatitis				Lupus			
High Blood Pressure				Tuberculosis				Liver Disease				Migraines			
Heart Attack				Thyroid Problem				Kidney Infections				Sleep Disorder			
Pacemaker				Diabetes				Kidney Disease				Sleep with CPAP			
Congestive heart failure				Eating Disorder				Anemia				AIDS or HIV			
Chest Pain				Depression				Abnormal bleeding				STD			
Stroke				Anxiety				Clotting Disorder/DVT				Cancer			
Fainting spells				Other Mental Health				Seizures				Radiation Therapy			

Do you have any disease, condition, or problem not listed above, that may be important to your health? Please explain:

_____
_____
_____
_____

Note: Both Doctor and patients are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a true health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of Patient/Legal Guardian Date

For Completion by Dental Examiner

Comments: _____
_____
_____

Has patient ever been pre-medicated and why? _____
_____