Health Information

We take your oral health very seriously. But before we start your treatment, we need some brief information on your medical history which may affect your treatment. All information is confidential.

Patient's Name: ____________________________Date of Birth: ____________
Reason for today's visit? _________________________ Date of last dental visit:___________
Have you been under the care of a physician? (circle) Yes No
Have you ever been treated for periodontal (gum) disease? (circle) Yes No
Are you taking or have taken Oral Bisphosphonates?(e.g., FOSAMAX, ACTONEL, BONIVA, (circle) Yes No Taken for how long? __________________________
Have you taken antibiotics prior to dental procedures in the past? (circle) Yes No
Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle) Yes No
List any medications you are allergic to: ____
List any medications you are taking including non-prescription drugs and herbals/vitamins:
____

Do you have a history of:	Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Pace Maker/ Heart Surgery		
Heart Murmur			Allergies or Hives			Pain in your Jaw (TMJ)		
Mitral Valve Prolapse			Anemia			Sinus Problems		
Diabetes			Teeth Grinding/ Clenching			Excessive Bleeding		
Venereal Disease			Arthritis			Stroke		
High Blood Pressure			HIV Positive/AIDS			Lung Disease		
Low Blood Pressure			Heart Problem			Breathing Problems		
Any type of Transplant			Chemotherapy			Tuberculosis (TB)		
Drug Addiction			Radiation Treatment			Mouth sores/growths		
Hepatitis (Type)			Thyroid Disease			Aspirin/Anticoagulant Therapy		
Liver Disease			Epilepsy or Seizures			Cancer (Type:)		
Kidney Disease			Fainting or Dizzy Spells			Any Artificial Hip, Knee or other Joint		

Other Disease or Illness:____
Women patients only:
Is there a possibility of pregnancy? (circle) Yes No Are you nursing? (circle) Yes No

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition.

Patient's Signature__________________________________ Date____________
Dr's. Signature______________________________________ Date____________