

Enriching Lives by Exceeding Expectations

General Health

Name: _____

Are you in good health? YES ___ NO ___

Are you currently under the care of a physician? YES ___ NO ___

If yes, please explain: _____

Physician's name: _____

Phone: _____

Please list all the medications currently being taken:

Do you smoke or use tobacco in any form: YES ___ NO ___

WOMEN ONLY: Are you pregnant? YES ___ NO ___ Due date _____

Are you nursing? YES ___ NO ___

Are you using birth control pills? YES ___ NO ___

Have you ever had any of the following? Please circle each one.

Heart Trouble	Y	N	Stroke	Y	N
High Blood Pressure	Y	N	Joint Replacement	Y	N
Rheumatic Fever	Y	N	Diabetes	Y	N
Heart Murmur	Y	N	Hepatitis	Y	N
Mitral Valve Prolapse	Y	N	HIV/AIDS	Y	N
Artificial Heart Valve	Y	N	Sinus Problems	Y	N

ARE YOU ALLERGIC TO OR REACTED ADVERSELY TO:

Local Anesthetic	Y	N	Aspirin	Y	N
Penicillin	Y	N	Codeine	Y	N
Sulfa Drugs	Y	N	Latex	Y	N

Is there anything additional you feel is important for us to know about your health?

Dental Health

Why have you come to the dentist today? _____

Many patients come to us for a second opinion or cosmetic treatment only. Are you currently seeing another dentist for your dental needs?

YES ___ NO ___ If yes, please explain: _____

How would you describe the condition of your teeth?

Good ___ Fair ___ Poor ___

How would you describe the condition of your gums?

Good ___ Fair ___ Poor ___

Are you currently having pain or discomfort in your teeth or gums?

YES ___ NO ___ If yes, please explain: _____

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

Do your gums bleed when you brush? YES ___ NO ___

When you floss? YES ___ NO ___

Are you concerned about bad breath? YES ___ NO ___

Have you ever had a problem with your jaw (TMJ) joint?

YES ___ NO ___ If yes, please explain: _____

Do you clench or grind your teeth while awake or when asleep?

YES ___ NO ___

If yes, do you have a bite appliance or nightguard? YES ___ NO ___

How often do you wear it? _____

If you had a magic wand, what would you change about the appearance of your teeth?

I understand that, to the best of my knowledge, the questions on this form have been accurately answered. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status or condition.

I authorize the dental staff to perform all necessary dental procedures that I may need with my informed consent. I also give permission to the doctor or his staff to use any photos he may take to be used for lecturing, publishing, or educational purposes.

Signature _____ Date _____

This area for doctor's notes

Please do not write below this line
