|  |
| --- |
| Name: Home Phone: Cell Phone:*Last First Middle* ( ) ( ) |
| Address: City: State: Zip: |
| Occupation: Employer: |
| Date of Birth: SS#: |
| Emergency Contact: Relationship: Phone Number: |
| Dental Insurance:*Are you the primary subscriber? Y / N Subscriber Name: Subscriber Date of Birth:**Relationship to subscriber:**Dental Insurance Company: Group Number: Policy/ ID number:* |

**COVID 19**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| Do you have a fever, felt hot or feverish, or had chills recently? | [ ]  | [ ]  |
| Are you having shortness of breath or other difficulties breathing? | [ ]  | [ ]  |
| Do you have a cough? | [ ]  | [ ]  |
| Any other flu-like symptoms such as gastrointestinal upset, headache, fatigue, muscle or body aches? | [ ]  | [ ]  |
| Have you experienced recent loss of taste or smell? | [ ]  | [ ]  |
| Are you in contact with confirmed Covid-19 positive patients? | [ ]  | [ ]  |
| Is your age over 60? | [ ]  | [ ]  |
| Have you traveled in the past 14 days to any regions affected by Covid-19? | [ ]  | [ ]  |
| Have you been vaccinated against Covid? | [ ]  | [ ]  |

**Dental Information**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| Do your gums bleed when you brush or floss? | **[ ]**  | **[ ]**  |
| Are your teeth sensitive to cold, hot, sweets or pressure? | **[ ]**  | **[ ]**  |
| Is your mouth dry? | **[ ]**  | **[ ]**  |
| Have you had any periodontal (gum) treatments like scaling and root planing? | **[ ]**  | **[ ]**  |
| Have you ever had orthodontic (braces) treatment? | **[ ]**  | **[ ]**  |
| Have you had any problems associated with previous dental treatment? | **[ ]**  | **[ ]**  |
|   | **YES** | **NO** |
| Are you currently experiencing dental pain or discomfort? | **[ ]**  | **[ ]**  |
| Do you have earaches or neck pains? | **[ ]**  | **[ ]**  |
| Do you have any clicking, popping or discomfort in the jaw? | **[ ]**  | **[ ]**  |
| Do you clench or grind your teeth? | **[ ]**  | **[ ]**  |
| Have you ever had a serious injury to your head or mouth? | **[ ]**  | **[ ]**  |
| Do you have sores or ulcers in your mouth? | **[ ]**  | **[ ]**  |
| Do you wear dentures or partials? | **[ ]**  | **[ ]**  |
| If so, how old is your current prosthesis? | **[ ]**  | **[ ]**  |
| Do you smoke? | **[ ]**  | **[ ]**  |
| *If yes, how much?* *[ ]  Fewer than 3 cigarettes per day*  |
| *[ ]  3 to 7 cigarettes per day* |
| *[ ]  More than 7 cigarettes per day* |
|  |  |
| Date of your last dental exam (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| What was done at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of last dental x-rays (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| What is the reason for your dental visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you unhappy with your smile? | **YES****[ ]**  | **NO** **[ ]**  |
| If yes, why? (Check all that apply) [ ]  Color of your teeth [ ]  Shape of your teeth [ ]  Position of your teeth |
| Other (please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Medical Information**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| Are you now under the care of a physician? | **[ ]**  | **[ ]**  |
| Physician name: Phone Number: |
| Are you in good health? | **[ ]**  | **[ ]**  |
| Has there been any change in your general health within the past year? | **[ ]**  | **[ ]**  |
| If yes, what condition is being treated? |
| Have you had a serious illness, operation or been hospitalized in the past 5 years? | **[ ]**  | **[ ]**  |
| If yes, what was the illness or problem? |
| Please list any blood thinners (such as coumadin, warfarin, Xarelto, Plavix, heparin or aspirin): |
| **Joint replacement:** Have you had an orthopedic total joint replacement? | **[ ]**  | **[ ]**  |
| Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If yes, have you had any complications?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you taking or scheduled to begin taking an antiresorptive agent ( like Fosamax, Bonica, Reclast, Prolia) for osteoporosis or Paget’s disease? |
| Do you use controlled substances (drugs) for either medicinal or recreational use? | **[ ]**  | **[ ]**  |
| If yes, what substance? |
| If yes, how often do you use? |
| Was the substance prescribed by a doctor? | **[ ]**  | **[ ]**  |
| Do you use vaping products? | **[ ]**  | **[ ]**  |
| Do you use tobacco or nicotine products (smoking, snuff, chew)? | **[ ]**  | **[ ]**  |
| If so, how often? |
| Do you drink alcoholic beverages? | **[ ]**  | **[ ]**  |
| If yes, how much alcohol did you have in the last 24 hours? |
| If yes, how much do you typically drink? |
|  [ ]  3 or fewer servings per week  |
|  [ ]  4 to 7 servings per week  |
|  [ ]  More than 7 servings per week  |
| **Women Only:**  |
| Are you pregnant? | **[ ]**  | **[ ]**  |
| If so, how many weeks? |
| Are you taking birth control? | **[ ]**  | **[ ]**  |
|  |
| **Allergies - Are you allergic to or have you had a reaction to: (check all that apply)** |
| [ ]  Local Anesthetics – If so, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specify reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Aspirin – Specify reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Antibiotics – If so, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specify reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Barbiturates, sedatives, or sleeping pills – If so, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specify reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Sulfa drugs – If so, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specify reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Codeine or other narcotics – If so, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specify reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Metals – If so, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specify reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Latex (rubber) – If so, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specify reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Food – If so, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specify reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Other – If so, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specify reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Conditions (check all that apply)**

|  |  |  |
| --- | --- | --- |
| [ ]  Artificial (prosthetic) heart valve | [ ]  Previous infective endocarditis | [ ]  Damaged valves in transplanted heart |
| **[ ]  Congenital heart disease (CHD) - Please specify below:** |
| [ ]  Unrepaired, cyanotic CHD | [ ]  Repaired (completely) in last 6 months | [ ]  Repaired CHD with residual defects |

|  |  |  |
| --- | --- | --- |
| **Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment?** | **YES**[ ]  | **NO**[ ]  |

**Other Conditions**

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Cardiovascular disease | [ ]  Angina | [ ]  Arteriosclerosis | [ ]  Congestive heart failure |
| [ ]  Heart attack | [ ]  Heart murmur | [ ]  Low blood pressure | [ ]  High blood pressure |
| [ ]  Mitral valve prolapse | [ ]  Pacemaker | [ ]  Abnormal bleeding | [ ]  Anemia |
| [ ]  Hemophilia | [ ]  AIDS or HIV infection | [ ]  Arthritis | [ ]  Autoimmune disease |
| [ ]  Asthma | [ ]  Emphysema | [ ]  Severe headaches / migraines | [ ]  Osteoporosis |
| [ ]  Tuberculosis | [ ]  Diabetes Type I or II | [ ]  Eating Disorder | [ ]  Gastrointestinal disease |
| [ ]  Ulcers | [ ]  Thyroid problems | [ ]  Stroke | [ ]  Hepatitis, Jaundice or liver disease |
| [ ]  Epilepsy | [ ]  Reflux / Persistent heartburn | [ ]  Kidney Problems | [ ]  Rheumatoid arthritis |
| [ ]  Blood transfusion | [ ]  Other congenital heart defects | [ ]  Damaged heart valves | [ ]  Seizures |
| [ ]  Persistent swollen glands in neck | [ ]  Sleep disorder | [ ]  Sleep apnea |  |
|  |  |  |  |  |
| [ ]  Cancer / Chemotherapy / Radiation Treatment Year Treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any radiation to head / neck? [ ]  YES | [ ]  NO | [ ]  Mental health disorders If yes, please specify: |
| [ ]  Neurological disorders If yes, please specify: |
|  |  |  |  |  |
| Do you have any disease, condition or problem not listed above that you think we should know about?Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**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 truthful 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 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_