|  |
| --- |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_