WELCOME

PERSONAL INFORMATION

Name____
Address____
Telephone: Home________________________Office_______________________________________
Date of Birth____________________________ Sex____________________ Marital Status__________
Employer________________________________Occupation____________________________________
Medical Doctor__________________________Phone number__________________________________
Nearest Relative_________________________ Phone number__________________________________
Do you have Dental Insurance_______________ Person Responsible for the account_________________
Email address____

MEDICAL HISTORY

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING (PLEASE CIRCLE)

Congenital Heart Defect	Yes	No	Rheumatic Fever	Yes	No
Heart Murmur	Yes	No	Mitral Valve Prolapse	Yes	No
Joint Replacement (knee/hip)	Yes	No	Heart Surgery	Yes	No
If yes, how long ago? _______			If yes, what type? _____________		

ANTIBIOTIC PRE-MEDICATION A "yes" to any of the above questions may require antibiotic Pre-medication or a release from your physician prior to any Dental treatment

Are you taking a blood thinner? Yes No Drug______________________
Have you ever had any serious illness or operation? Yes No Reason____________________
Have you been a patient in a hospital in the past 5yrs? Yes No
Reason____________________

PLEASE CIRCLE IF YOU HAVE ANY OF THE FOLLOWING:

AIDS/HIV Positive	Diabetes	Pacemaker
Alzheimer's disease	Emphysema	Paralysis
Anemia	Epilepsy	Parkinson's disease
Arthritis/Rheumatism	Fainting	Pneumonia
Artificial Heart Valves	Glaucoma	Respiratory Disease
Asthma	Headaches	Scarlet Fever
Back Problems	Heart Attack	Sexually Transmitted Diseases
Blood Disorder	Heart Disease	Shortness of Breath
Cancer	Hemophilia	Stroke
Chemotherapy/Radiation	Hepatitis A,B,C	Swelling of feet/ankles
Circulatory Problems	High/Low Blood Pressure	Thyroid Problems (hyper/hypo)
Cough, Persistent	Kidney/Liver Disease	Tobacco Habit
Depression/Anxiety	Nervous Problems	Tuberculosis

Please explain any circled answer ____
Also, list any other medical conditions or ____
Limitations you have that are not listed above. ____

MEDICATIONS

List medications you are currently taking:
____
____
____
____

ALLERGIES (please circle)

Aspirin	Barbiturates (sleeping pills)
Codeine	Erythromycin
Latex	Penicillin
Sulfa	Other_______________________

____

DENTAL HISTORY

How often do you brush? _________________ How often do you floss? ___________________

Please circle any of the following conditions that apply to you:

Bad Breath	Grinding teeth	Sensitivity to hot
Bleeding Gums	Loose teeth/broken fillings	Sensitivity to Sweet
Clicking/sore/popping Jaw	Periodontal treatment	Sensitivity when biting
Food collection between teeth	Sensitivity to cold	Sores/growths in your mouth

Is there anything else in your dental or medical history we should know?
____
____
____
____
_____ ____

I certify that the information I have given on this medical history form is correct and complete to the best of my knowledge. I also understand that complete, correct and up-to-date information is important for my well-being and safety. I understand and agree that it is my responsibility to inform the hygienist of any changes in my medical status **before** any treatment is rendered.

CLIENT SIGNATURE__________________________________ DATE__________________________