CONFIDENTIAL PATIENT INFORMATION PAGE 2

Health and Dental History

Name ____________________________

DENTAL HISTORY (CIRCLE YES OR NO AS NEEDED)		
Are you having PROBLEMS or DISCOMFORT now?	Yes	No
PLEASE DESCRIBE		
Do you wear DENTURES?	Yes	No
Have you had any PERIODONTAL (GUM) Treatment?	Yes	No
Do your gums BLEED or feel TENDER or IRRITATED?	Yes	No
Are your teeth SENSITIVE to hot, cold, sweets or pressure?	Yes	No
Are you aware of GRINDING or CLENCHING your teeth?	Yes	No
Have you worn BRACES? (ORTHODONTICS)	Yes	No
If yes, do you wear a RETAINER?	Yes	No
Would you like to change the APPEARANCE of your SMILE?	Yes	No
PLEASE DESCRIBE		
Are you APPREHENSIVE about dental treatment?	Yes	No
Have you ever been or interested in being SEDATED for dental treatment with drugs or NITROUS OXIDE (LAUGHING GAS)?	Yes	No
When was your last visit to a dentist and for what reason?		
When was your last exam and cleaning?		
Please describe any other information you feel we should know:		
Have you been told to take an ANTIBIOTIC PREMEDICATION before any dental treatment by a dentist or physician?	Yes	No
If yes, for what reason?		

MEDICAL HISTORY (CIRCLE YES OR NO AS NEEDED)		
Do you have any current HEALTH PROBLEMS?	Yes	No
Are you under a PHYSICIAN'S CARE?	Yes	No
PLEASE DESCRIBE		
What MEDICATIONS do you take and for what REASON do you take it:		
Are you aware of any medications you are ALLERGIC to?	Yes	No
PLEASE LIST		
Are you allergic to LATEX?	Yes	No
Are you PREGNANT?	Yes	No
Do you SMOKE?	Yes	No

Please circle any of the following conditions you have had or presently have:

Prosthetic (Hip, Knee, etc.)	Heart Disease or Attack	Heart Murmer
Mitral Valve Prolapse	Rheumatic Fever	Stroke
Diabetes	Kidney Problems	Liver Disease
High/Low Blood Pressure	Hepatitis	Tuberculosis (TB)
AIDS or HIV Positive	Cancer/Chemotherapy	Asthma
Pacemaker	Drug/Alcohol Addiction	

Other: PLEASE LIST BELOW

Do you take any herbal supplements? If yes please list below

Family Physician ____ City/State of Clinic _______________________________________

The undersigned hereby attests that the above information is complete and accurate.

PATIENT SIGNATURE (Parent if under 18) ____ DATE ____ / ____ / _______