Patient Information Form

Date___/___/___

An accurate and complete health history will assist in coordinating your dental care.
Please speak with the doctor or staff if there are any questions about this form.

First Name_____ MI_____ Last Name_____

Preferred Name_____ DOB _____/_____/_____ Gender: M____ F_____

Contact Information

Home Phone _____ Mobile Phone _____

Email Address _____

Street Address _____

City _____ State_____ Zip Code _____

Emergency Contact _____ Phone Number _____

Dental Information

Do you have or have you ever had any of the following? (Circle YES or NO)

Bleeding/Sore Gums	Y	N	Sensitive to Biting	Y	N
Bad taste in your mouth	Y	N	Bite Changes/Shifting in Bite	Y	N
Swelling/lumps in your mouth	Y	N	Burning Tongue/Lips	Y	N
Orthodontic Treatment (Braces)	Y	N	Frequent Blisters/Ulcers	Y	N
Periodontal Treatment (Gums)	Y	N	Clicking/Popping of Jaw/TMJ	Y	N
Clenching/Griding/Night guard	Y	N	Difficulty Opening/Closing your Jaw	Y	N
Sensitive to Sweets/Hot/Cold	Y	N	Loose Teeth	Y	N

Date of Last Dental Visit _____

Medical Information

Do you have any of the following allergies? (Circle YES or NO)

Latex	Y	N	Aspirin	Y	N	Fluoride	Y	N	Iodine	Y	N
Penicillin	Y	N	Tylenol	Y	N	Anesthetic	Y	N	Seasonal	Y	N
Erythromycin	Y	N	Ibuprofen	Y	N	Acrylic	Y	N	Other_____		
Sulfa	Y	N	Codeine	Y	N	Metals	Y	N	Other_____		

Are you currently taking any medications? (If Yes, Please List Below or Attach Separate List)

_____

_____

_____

TURN OVER TO COMPLETE BACK OF FORM ➡

Do you have any of the following health conditions? (Circle YES or NO)

Blood Disease/Clotting Disorder/Anemia	Y	N	Autoimmune Disease	Y	N
Asthma/COPD/Emphysema	Y	N	Diabetes	Y	N
Sleep Apnea	Y	N	Kidney Disease/Dialysis	Y	N
Angina/Chest Pain	Y	N	Syncope/Fainting	Y	N
Heart Disease/Congestive Heart Failure	Y	N	Epilepsy	Y	N
Heart Attack	Y	N	Glaucoma	Y	N
A-Fib	Y	N	Hearing Trouble	Y	N
Artificial Heart Valves	Y	N	Osteoporosis or Osteopenia	Y	N
Congenital Heart Defects	Y	N	Rheumatoid Arthritis	Y	N
High or Low Blood Pressure	Y	N	Sinus Trouble	Y	N
Stroke	Y	N	TMJ Disorder	Y	N
Pacemaker	Y	N	Chronic Pain	Y	N
Gastrointestinal Disease/Reflux	Y	N	Eating Disorder	Y	N
Hepatitis/Jaundice/Liver Disease	Y	N	Frequent Headaches	Y	N
Sexually Transmitted Disease	Y	N	Gout	Y	N
HIV/AIDS	Y	N	Cancer/Chemotherapy/Radiation	Y	N
Thyroid Problems	Y	N	Neurological Disorders	Y	N
Anxiety/Depression	Y	N	Rapid Weight Loss	Y	N
Psychiatric Care	Y	N	Other _____		
Alzheimer's/Dementia	Y	N	Other _____		

Do you take any blood thinners or anticoagulants such as Coumadin, Warfarin, Plavix, Clopidogrel, Xarelto, Eliquis, Pradaxa, Brilinta? Y N

Have you ever taken Actonel, Fosamax, Boniva, Reclast, Aredia, Prolia, Xgeva or any other bisphosphonate drug used to treat osteoporosis or bone cancer? Y N

Have you ever had Radiation Treatment to your head/neck? Y N

Do you have any total joint replacements (Hip/Shoulder/Knee/etc.)? Y N

Do you smoke tobacco, cigarettes, vapes, marijuana or use chewing tobacco/dip? Y N

Female Patients: Are you pregnant, trying to become pregnant, or breast feeding? Y N

I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care. To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature of patient, parent, guardian Date

_____

Printed name of patient, parent, guardian/Relationship