Patient Information

Name ____

Birth Date ____

Address ____

____

____

____

Email ____

Phone ____

____

Emergency Contact

Name ____

Phone ____

Dental History

Do you have a specific dental concern? ____
When was your last dental visit? ____
How often have you seen dentist/hygienist? ____
How often do you brush your teeth? ____
How often do you floss your teeth? ____
Do your gums bleed? ____
Do you clench or grind your teeth? ____
Experienced popping/clicking of your jaw? ____
How do you feel about your smile? ____
Do you have well water at home? ____
Do you suck on mints or cough drops? ____
Have you had any unpleasant dental experiences in the past?
____
Do you play sports or lift weights? ____
Do you wear a mouth guard? ____
Do you drink soda/energy drinks? ____
How many a day? ____
Do you have difficulty swallowing? ____

Medical History

Are you taking or have you ever taken FOSAMAX, ACTONEL or other BISPHOSPHONATES? ____
Do you have diabetes? ____
If yes, is it controlled? ____
Is there a family history of diabetes? ____
Do you have any artificial joints (joint replacements)?
____
Have you had a TRANSPLANT or ARTIFICIAL VALVES?
____
Are you taking COUMADIN or other anticoagulants?
____

Do you use TOBACCO? ____
Are you interested in quitting? ____
Do you use vaping pens or similar products? ____
Do you use Marijuana? ____

Have you been told that you snore? ______________________________________

Have you been told you have sleep apnea? ______________________________________

Are you in good health? ______________________________________

Have you been under a doctor’s care in past 2 years?

____

Have you been hospitalized in past 5 years? ______________________________________

Physician’s name: ____

Please list medications:____

____

Do you take vitamins/herbal preparations?_____________________________________

WOMEN: Are you pregnant or taking birth control?

____

Please list ALL allergies:____

____

____

Please circle if you have any of the following:

High Blood Pressure
Pacemaker/Defibrillator
Peripheral Artery Disease
Hepatitis
HIV Positive
Stent
Bypass surgery
Hemophilia
Anemia

Breathing Difficulty
Sinus Trouble
Pneumonia
Chronic Cough
Asthma
Tuberculosis
Bronchitis

Memory Lapses
Panic Attacks
Communication Difficulties
Hearing Loss
Learning Disabilities
Psychiatric Disorder

Kidney Disease
Dialysis
Rheumetoid Arthritis
Epilepsy
Cancer
Chemo/Radiation
Alcoholism
Substance Abuse
Glaucoma
Dizziness
Gastrointestinal Problems
MRSA