NAME:_____ Date of Birth:_____
Address:_____ Postal Code:_____
Phone (cell#):_____ (home#):_____
Business/Work #:_____
Email Address:_____
Occupation:_____ Personal Physician: _____
Employer: _____ Phone#: _____

MED – DENT **ALERT**

Do you require **PREMEDS**?
YES / NO

DENTAL INSURANCE INFORMATION:

Insurance Company Name(s)

#1_____ #2_____
ID #_____ ID#_____
Policy #_____ Policy#_____
Employer_____ Employer_____

MEDICAL HISTORY

1) In general my health is: GOOD ☐ FAIR ☐ POOR ☐

	YES	NO
2) Are you presently under the care of a Medical Doctor? If YES, for what?_____	☐	☐
3) My last physical exam was on:_____		
4) Was anything unusual or abnormal found?_____	☐	☐
5) Have you ever had a serious illness? If YES, what?_____	☐	☐
6) Have you ever required a blood transfusion?_____	☐	☐
7) Are you taking any medications, drugs, or pills of any kind? If YES, what and why?_____	☐	☐
8) Do you have any **allergies**? If YES, to what and how do you react?_____	☐	☐
9) Have you ever had an unusual reaction to dental freezing?_____	☐	☐
10) Have you ever had abnormal bleeding with surgery, injuries or extractions?_____	☐	☐
11) Have you ever had surgery or X-ray treatment for a tumor, growth or other condition in your mouth, neck or face?_____	☐	☐

12) Have you ever had any of the following disorders:

	Yes	No		Yes	No		Yes	No
Rheumatic Fever	☐	☐	High Blood Pressure	☐	☐	Jaundice	☐	☐
Rheumatic Heart Disease	☐	☐	Diabetes	☐	☐	Hepatitis	☐	☐
Congenital Heart Disease	☐	☐	Kidney Disease	☐	☐	Venereal Disease	☐	☐
Heart Attack	☐	☐	Tuberculosis	☐	☐	Blood Disorder	☐	☐
Stroke	☐	☐	Asthma	☐	☐	HIV and/or AIDS	☐	☐

13) Are you frequently bothered by:

	Yes	No		Yes	No		Yes	No
Sinus Problems	☐	☐	Bruise easily	☐	☐	Shortness of breath	☐	☐
Ear problems	☐	☐	Dizziness or fainting	☐	☐	Excessive nervousness	☐	☐

14) WOMEN **ONLY**: Are you pregnant? **YES** **NO** If yes, which month?_____

What brings you to the dentist today?_____
When was your last dental visit?_____ Previous Dentist?_____
What did you have done at that visit?_____
How often do you BRUSH your teeth?_____ Floss your teeth?_____
Any dental concerns regarding your oral health or the look of your smile?_____
_____
_____

Do you have or are you experiencing any of the following:

	YES	NO			YES	NO
The fear of dentistry/dentist	Y	N	Pain in:	Face	Y	N
Bleeding gums	Y	N		Jaw	Y	N
Bad breath	Y	N		Ears	Y	N
Discolored teeth	Y	N		Neck	Y	N
Crooked teeth	Y	N		Mouth	Y	N
Missing teeth	Y	N		Opening wide	Y	N
Hot/Cold sensitive teeth	Y	N	Frequent headaches		Y	N
Not able to floss between teeth	Y	N	Clicking or popping in jaw		Y	N
Food packing between teeth	Y	N	Grinding teeth or clenching jaws		Y	N
Swelling or lump in mouth or face	Y	N	Complications with tooth removal		Y	N

NOTES : _____
_____
_____
_____
_____

How did you hear about our office?

- ☐ Referral by friend/family: **Name**:_____
- ☐ Website
- ☐ Another Dentist / Doctor **Name**:_____
- ☐ Google
- ☐ Advertisement

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated. I fully understand the office policy and I will assume responsibility for fees associated with the procedures performed. I also consent to the collection, use, retention and disclosure of personal information as is required for my own and my dependents dental care.

Patient's (Parent's) Signature_____Date_____