Dental History

Patient	Name:		Date of Birth:	Date of Birth:	
Dates: Last dental appt:		X-ra	ys:Clea	eaning:	
Name of former dentist:			Phone #:	#:	
Do you have a denture? Yor N If yes how old? Partial? Y or N If yes how old? Implant? Y or Do you have a dental problem? PLEASE EXPLAIN:					
Drimary	, Caro Physician:		<u>ical History</u>	Phono:	
Y or N	y Care Physician: Phone: Phone: Are you currently being treated by a physician?				
1 01 14	If so, what are you being treated for?				
Y or N	Are you taking medications? **COMPLETE LIST IS REQUIRED!**				
Y or N	Any recent hospitalizations? List:				
Y or N	Allergic to any medications? List:				
Yor N	Are you allergic to latex?				
Y or N	Do you need antibiotics before a dental visit?				
Y or N	Have you ever had a joint replacement? (Knees, hips, etc) Date:				
Y or N	•	•	· · · · · · · · · · · · · · · · · · ·		
Y or N	•	•			
Y or N	History of bisphosphonates? Oral or IV				
Y or N					
1 01 14	No you take any blood thinners? (i.e. Coumadin, Plavix, etc) List: Has Rx been changed Yor I				
Y or N	Do you use tobacco		it was the last reading?	rias KX been changed Tor N	
Y or N	•		er? Date:		
Y or N	•	_	? Early State: Mid Stage:		
Y or N	•		ou able to transfer to a denta		
1 01 14	Do you use a. Scoo l	ei Walkei Ale yo	ou able to transier to a dente		
		Circle all	conditions that apply:		
	AIDS/HIV	Congestive Heart	Heart Disease	Parkinson	
		Failure			
Al	zheimer/Dementia	COPD	Hepatitis	Respiratory Disease	
			·		
,	Anxiety/Nervous	Depression	High blood pressure	Seizures	
	Disorder	·			
Ble	eeding gums/ Gum	Diabetes	Loose/Sensitive teeth	Swollen feet/ankles	
	disease				
	Blindness	Grinding teeth	Low blood pressure	Tuberculosis	
		J			
	Cancer (type)	Headaches	Mitral valve prolapse	Weight loss (sudden)	
	()1 /			, ,	
	Chronic Pain	Hearing loss	Oxygen use	Other:	
			7.5		
certify	that above information	about my medical history	y is accurate. I authorize and	give consent for my dentist to	
erform	dental services agree	d upon as well as discuss	dental care with my PCP.		
Χ					
	MUST SIGN HERE	GUARDIAN/PATIENT/F	POWER OF ATTORNEY	DATE	
X					
		DENTIST		DATE	