

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws.

PATIENT INFORMATION

First Name:

Last Name:

Date of Birth:

MEDICAL INFORMATION

Do you use tobacco (smoking, snuff, chew, vaping)?

Yes [] No []

Do you consume alcohol or use recreational drugs?

Yes [] No []

Have you had a serious illness, operation or been hospitalized in the past 5 years?

Yes [] No []

Have you been instructed by a physician or dentist to take antibiotics prior to dental treatment for a heart condition or joint replacement?

Yes [] No []

Are you currently under the care of a physician?

Yes [] No []

***If you are currently under the care of a physician, please complete the "Physician Information" section.*

**PHYSICIAN INFORMATION

Physician Name:

Physician Phone Number:

Date of last visit:

Did you have bloodwork completed as part of your last visit?

Yes [] No []

HABITS

PLEASE MARK YES OR NO IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

Thumb/finger sucking

Yes [] No []

Lip sucking/biting

Yes [] No []

Mouth breather

Yes [] No []

Tongue Thrust

Yes [] No []

Speech problems

Yes [] No []

Nail biting

Yes [] No []

MEDICATION

Are you prescribed blood thinners? (Aspirin, Heparin, Warfarin, etc.)

Yes [] No []

Have you ever taken any medications containing bisphosphonates (i.e. Fosamax and Boniva)?

Yes [] No []

Are you currently taking any GLP-1 medications for weight loss?

Yes [] No []

Are you taking any prescription or over the counter medication(s)?

Yes [] No []

Please list all prescribed or over the counter medication(s).

ALLERGIES

Aspirin Yes [] No []

Codeine or other Yes [] No []
narcotics

Tetracycline/ Yes [] No []
Erythromycin/Penicillin/
Other antibiotics

Latex (rubber) Yes [] No []

Yes [] No []

Yes [] No []

Allergies

Date Of Replacement or Implant:

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PLEASE MARK YES OR NO IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

Artificial (prosthetic) heart valve	Yes []	No []	Congenital heart disease (CHD)	Yes []	No []
Cardiovascular disease	Yes []	No []	Chest pain / Angina	Yes []	No []
Arteriosclerosis /	Yes []	No []	Congestive heart failure	Yes []	No []
Coronary artery disease					
Heart attack	Yes []	No []	Heart murmur	Yes []	No []
Low blood pressure	Yes []	No []	High blood pressure	Yes []	No []
Mitral valve prolapse	Yes []	No []	Pacemaker	Yes []	No []
Cardiac stent	Yes []	No []	History of Endocarditis	Yes []	No []

MEDICAL CONDITIONS, DISEASES, AND PROBLEMS

PLEASE MARK YES OR NO IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

Pregnant/Nursing?	Yes []	No []	Taking birth control pills or hormonal replacement?	Yes []	No []
Hemophilia / Abnormal bleeding	Yes []	No []	Blood transfusion	Yes []	No []
Anemia	Yes []	No []	Autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma)	Yes []	No []
HIV + / AIDS	Yes []	No []	Arthritis / Pain in joints	Yes []	No []
Asthma / Breathing problems	Yes []	No []	Tuberculosis	Yes []	No []
Emphysema / Bronchitis / Persistent cough	Yes []	No []	Sinus trouble	Yes []	No []
Rheumatic fever	Yes []	No []	Hearing or Vision Impairment	Yes []	No []
Cancer / Chemotherapy / Radiation	Yes []	No []	Chronic pain	Yes []	No []
Diabetes	Yes []	No []	Glaucoma	Yes []	No []
Hepatitis / Jaundice / Liver disease	Yes []	No []	Mental Health Conditions (e.g., anxiety, depression, bipolar)	Yes []	No []
Neurological disorders	Yes []	No []	Snoring	Yes []	No []
Sleep disorder	Yes []	No []	Severe / Rapid weight loss	Yes []	No []
Eating disorder / Malnutrition	Yes []	No []	Gastrointestinal disease	Yes []	No []
Reflux / Persistent heartburn	Yes []	No []	Sores / Ulcers in the mouth	Yes []	No []
Thyroid problems	Yes []	No []	Stroke	Yes []	No []
Epilepsy / Seizures	Yes []	No []	Dizziness / Fainting	Yes []	No []
Recurrent Infections	Yes []	No []	Kidney problems	Yes []	No []
Night sweats	Yes []	No []	Osteoporosis	Yes []	No []
Persistent swollen glands in neck	Yes []	No []	Frequent / Severe headaches	Yes []	No []
Sexually transmitted	Yes []	No []	Difficulty urinating /	Yes []	No []

infection

Do you have any other diseases, conditions, problem, or special needs or accommodations not listed above?

Prostate

Yes [] No []

Please list any other diseases, conditions, problem, special needs or accommodations not listed above.

Problems

SIGNATURE

I consent to use Electronic Records and Signatures: []

I certify that to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients') health. I acknowledge that It is my responsibility to inform the dental team of any changes in medical status and I will not hold my doctor, affiliated entities, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.