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Today's Date:

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need to treat you.

PATIENT INFORMATION:

Last Name: _____ First Name:_____ Middle name: _____

Home Phone: _____ Cell phone: _____ Work phone: _____

Email Address: _____ Mailing Address: _____City: _____ State: ___ Zip:_____

Date of Birth: ____/____/_____ Gender: _____ Occupation: _____

Emergency Contact Name: _____Relationship: _____ Cell Phone: _____

If you are completing this form for another person, what is your name and relationship to that person?
Name: _____ Relationship: _____

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

_____

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today? _____

Are you currently experiencing any dental pain or discomfort? Y__ N __, If yes, where?_____

When was your last dental exam?___/____/___ What was done at that appointment?_____

When was the last time you had dental X-rays taken?____/___/_____

_____

Please use an "X" to mark your answers to the following questions.

Is it hard to open your mouth?Y____N___Does it hurt to chew, bite or swallow? Y_____N_____

Do your gums bleed when you brush or floss your teeth?Y___N____ Have you ever had periodontal (gum) treatments like scaling and root planing?Y____N_____

Do you have, or have you ever had, any sores or growths in your mouth?Y____N____ Do you **clench or grind** your teeth?Y____N_____
Does your jaw click, pop, or hurt?Y____N_____Do you have earaches or neck pain?Y____N____ **Does dental treatments make you nervous? Y____N ____**

Have you ever experienced any of these sleep-related breathing disorders? Mouth breathing:Y___N__ Snoring: Y___N___ Trouble breathing during sleep: Y_____N ____

Have you ever had a serious injury to your head or mouth? Y___N__If yes, please describe what happened and when it happened:_____

Have you ever had problems with dental treatment in the past?Y_____N_____If yes, please describe what happened: _____

Have you ever had a reaction to, or problem with, dental anesthesia?Y____N_____If yes, please describe what happened:_____

Are you unhappy with your smile? If yes, why? Please mark all that apply: The color of your teeth: Y_____N_____ The shape of your teeth: Y_____N____ The position of your teeth: Y_____N____

Other, Please describe: _____

_____

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please use an "X" to mark your answers to the following questions.

Are you taking any **blood thinners**? (Such as Coumadin, Warfarin, Clopidogrel (Plavix) rivaroxaban (Xarelto), dabigatran (Pradaxa), heparin or aspirin?**Y_____N____**If yes, what medication are you taking?_____

Are you taking any medication to treat **osteoporosis** or Paget's disease? Y____N____ Some commonly prescribed drugs include: Alendronate (Fosamax), Risedronate (Actonel), ibandronate (Boniva), zoledronate (Reclast), and denosumab (Prolia) Y____N____ If yes, what medication are you taking? _____

Are you taking or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?Y_____N___Some commonly prescribed drugs include: denosumab (Xgeva), pamidronate (Aredia), or zoledronate (Zometa) If yes, what medication are you taking?_____ How many years have you been taking it?_____

Are you taking hormonal replacement? Y____N_____

Do you use any form of tobacco or nicotine products (Cigarettes, cigars, snuff, chew, bidis)? Y__N__ Do you use vaping products?Y___N___

How many **alcoholic beverages** do you have per week?_____

Do you use **controlled substances (Drugs**), including marijuana, for either medicinal or recreational reasons? Y_____N_____

If yes, what substances?_____If yes, how often do you use it? Daily____, Several times per week____Weekly____Occasionally_____
Did a doctor prescribe the substance? Y____N_____If yes, for what reasons?_____

Do you take any **other prescriptions and/or over-the-counter medicine(s), vitamins, herbs, and/or supplements**?Y___N_____ If yes, please list them here and include information about how much and how often you use each one:_____
_____

WOMEN ONLY:
Are you taking birth control pills? Y_____N_____ **Pregnant**?Y_____N_____ If yes, number of weeks:_____

Nursing?Y_____N_____ If yes, number of weeks:_____
_____

ALLERGIES:
Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an **allergic reaction** to:

Aspirin: Y____N_____ Barbiturates, sedatives or sleeping pills: Y_____N_____ **Codeine or other narcotics**: Y__N___ Hay Fever / seasonal allergies: Y____N___ Iodine: Y____N___ **Latex** (rubber): Y_____N____ **Local anesthetics**: Y___N_____
Metals: Y___N___ **Penicillin or other antibiotics:** Y__ N___
Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim erythromycin-sulfisoxazole, sulfasalazine (Azulfidine), erythromycin sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTatis). dapsone, sumatriptan Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microride) and furosemide (Lasix) Y____N___
Other: Please describe any "Yes" answers and include information about your experience:_____
_____

MEDICAL & SURGICAL HISTORY
Date of last physical exam: _____/ _____/_____ What is your normal blood pressure (systolic, diastolic)?___/___ mmHg
Doctor's Name:_____ Phone:_____
_____
Please use an "X" to mark your answers to the following questions.

Are you in good physical health?Y___N__ Are you currently being seen or treated by a physician?Y__N___

Has a physician or previous dentist recommended that you take antibiotics before having dental work done?Y___N____

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

Have you had any type (either total or partial) of **joint replacement surgery (such as for a hip, knee shoulder elbow, finger, etc**.)? Y_____N____

Have you had a **heart valve replacement or heart surgery**?Y____N_____ Have you had an organ or bone marrow/stem cell transplant?Y_____N____ Have you traveled internationally within the last 30 days? Y_____N_____
Have you had a **fever (100 4°F or above) in the last 72 hours**? Y___N____

If you answered **yes** to any of the above, please explain:_____
_____

MEDICAL HISTORY SPECIFIC:
Please use an "X" to mark your answers to the following questions.
Do you have, or have you been diagnosed with, any of the following conditions?

Heart (Cardiac) Health? Y____N___ Pacemaker/ implanted defibrillator: Y___N_____ **Artificial (prosthetic) heart valve**: Y___N____

Previous infective endocarditis: Y___N___ Congenital heart disease (CHD): Y___N___ Unrepaired, cyanotic CHD: Y____N___

Repaired (completely) in last 6 months: Y___N_____ Repaired CHD with residual defects: Y____N___

Arteriosclerosis: Y____ N___ Coronary artery disease: Y___N__ Congestive heart failure: Y___N___ Stroke: Y____N____

Damaged heart valves: Y___N__ Heart attack: Y__ N__ Heart murmur/rhythm disorder: Y___N___ Rheumatic heart disease: Y____N____

Breathing (Respiratory) Health
Asthma (COPD): Y____N___ Bronchitis: Y___N___ Emphysema: Y___N___ Sinus trouble: Y___N___ Tuberculosis: Y____N____

Cancer: Y____N____ If yes, Type: _____ Date of diagnosis: ___/___/____ **Chemotherapy**: Y___N____ Radiation treatment: Y___N____

Blood (Circulatory) Health

Anemia: Y____N___ Blood transfusion: Y___N___ If yes, date: ___/___/____ **Hemophilia**: Y____N___

High blood pressure: Y____N____ Low blood pressure: Y___N____

Brain (Neurological)/Mental Health

Anxiety: Y___N____ **Depression**: Y____N____ **Epilepsy:** Y___N___

Mental health disorders

Neurological disorders: Y____N____ Post-traumatic stress disorder: Y____N____

Traumatic brain injury or concussion: Y____N____

Autoimmune Disease: Y___N____ If yes, what type: _____

AIDS or HIV Infection: Y____N____ If yes, are you under an active treatment regimen: Y___N____ Lupus: Y___N____

Digestive Health
Gastrointestinal disease: Y___N___ G.E. reflux/persistent heartburn (GERD): Y__N__ Stomach ulcers: Y__N__

Eye (Vision) Health Glaucoma: Y___N___ Other: _____

Arthritis: Y__N__ Chronic pain:Y___N___ **Diabetes (type I or II):** Y__N__ If yes, last **HbA1C** result:____

Eating disorder:Y___N____ Frequent infections:Y___N___ If yes, what type of infection:_____

Hepatitis, jaundice or liver disease: Y____N_____ Immune deficiency: Y___N___ Kidney problems: Y___N___ If yes, are you under dialysis: Y___N____

Malnutrition: Y___N___ Osteoporosis: Y____N_____ Rheumatoid arthritis: Y____N____

Sexually transmitted infection (STI): Y____N____ Thyroid problems: Y____N____

Do you have any disease, condition, or problem that's not listed here? If so, please explain:_____

MEDICAL SYMPTOMS/GENERAL

Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you had pain or tightness in the chest? Y___N___ coughed up blood or had a

cough that lasted longer than 3 weeks?Y___N___ been exposed to anyone with tuberculosis? Y___N__

had a rapid or irregular heartbeat?Y___N____ found it hard to catch your breath? Y___N___ **had a high fever (greater than 101.5°F) for no reason**? Y___N____ noticed a change in your vision?Y___N___ fainted for no reason?Y___N___ experienced vomiting, diarrhea, chills, night sweats or bleeding?Y____N___ had migraines or severe headaches? Y____N____

NOTE: It's important for both the doctor and the patient to talk honestly about the patient's health before dental treatment starts.

I have answered the above questions completely, accurately, and to the best of my ability.

Signature of Patient/Legal Guardian:

Date:

FOR COMPLETION BY DENTIST: _____ Comments:_____

Office Use Only:_____

Medical Alert:_____ Premedication:_____

Allergies:_____ Anesthesia:_____

Reviewed by: Dr. Aberoumand Date: / /