

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. Please note that you may be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient _____ Date _____

Are you in good health?	Yes / No
Have you had a serious illness, operation, or hospitalization in the past five years?	Yes / No
If yes, please describe:	
Have you ever been told you need to <u>regularly</u> take antibiotics before dental treatment?	Yes / No
Have you ever had a joint replacement?	Yes / No
If so, when and describe any complications?	
Have you ever taken Fosamax, Zometa, Aredia, Boniva or any other oral or intravenous bisphosphonates (used for osteoporosis)?	Yes / No When?
Are you pregnant or nursing?	Yes / No
Circle below if you are allergic to: Local anesthetics ("Novocaine") Latex Penicillin or other antibiotics Aspirin Sulfa drugs Codeine or other narcotics Metals Hay fever/seasonal Other (specify)	
Please list your prescriptions, over-the-counter medications, vitamins, natural/herbal preparations, and/or supplements:	

Please list any significant medical conditions, for example: Hepatitis, HIV, TB, Epilepsy, High Blood Pressure, Asthma, Endocarditis, Heart/Valve issues, Stroke, Cancer, Diabetes...	

What is your chief dental concern? _____

When was your last dental treatment? _____

Please check any of the following that concern you:

- Teeth sensitive to cold, heat, sweets, pressure, or biting
- Painful teeth or gums
- Bleeding gums
- Tooth decay (cavities or "caries")
- Missing teeth / gaps or spaces
- Crooked teeth
- Teeth too yellow
- Teeth chipped or fractured
- Clenching or grinding
- Wisdom teeth
- Food impaction between teeth
- Swelling or lumps in mouth
- Frequent sores on lips or in mouth
- TMJ (jaw joint) treatment or issues
- Pain around ear or jaw
- Bad breath ("halitosis") / unpleasant taste in mouth
- Complications from extractions
- Periodontal (gum) treatment
- Orthodontic treatment
- Mouth breathing / trouble breathing through nose
- Tobacco consumption
- Oral habits (i.e. nail biting, cheek biting, etc.)
- Previous bad dental experiences
- Dental fear / anxiety

Anything else you'd like to discuss with us?

To the best of my knowledge, all of the information provided is complete and accurate. I will inform my dentist of any changes.

Patient/Guardian's Signature _____ Date _____