All Smiles DENTAL CARE

HEALTH INFORMATION FORM

The practice of dentistry involves treating the whole person. Therefore, before we begin, we require some brief information regarding your medical history. Your medical history may affect your dental treatment. ***ALL INFORMATION IS CONFIDENTIAL.***

Patient's Name:_____ Date of Birth:_____ Last Physical Date:_____

Have you been treated by a physician? (circle) **Yes/No** Physician's Name & Phone #:_____

Reason for today's visit? _____

Are you in pain now? **Yes/No** Are you interested in tooth whitening? **Yes/No** Are you currently wearing dentures/partials? **Yes/No**

If wearing dentures/partials, age of prosthetic: _____ Are you interested in new dentures/partials? **Yes/No**

Are you taking or have taken Oral Biphosphonates, e.g., Fosamax, Actonel, Boniva, or IV Biosphonates, e.g., Zometa, Aredia? **Yes/No**

Are you currently taking any blood thinners, e.g., Aspirin, Coumadin, Warfarin, Plavix, or Xarelto? **Yes/No**

Have you taken antibiotics prior to dental procedures in the past? **Yes/No**

Have you had an adverse reaction/become ill to penicillin, aspirin, codeine, local anesthetics, latex, or any other medication? **Yes/No**

Please list any medications you are allergic to: _____

Please list any medications you are taking (including non-prescription drugs, and herbals/vitamins): _____

_____

Do you have a history of?	Y	N		Y	N		Y	N
Allergies/Hives			Epilepsy/Seizures			Psychiatric Treatment		
Anemia			Excessive Bleeding			Respiratory Problems		
Arthritis			Fainting or Dizziness			Rheumatic Fever		
Artificial joints (Knee, Hip, other)			Heart Problems - Specify:_____			Sinus Problems		
Any Implant/Transplant			Hepatitis - Type:_____			Steroid/Cortisone Therapy		
Aspirin/Anticoagulant Therapy			High Blood Pressure			Stroke		
Asthma			HIV Positive/Aids			STI's/Venereal Diseases		
Blood Diseases/Disorders			Kidney Disease			Thyroid Problems		
Breathing Problems			Liver Disease			Teeth Grinding/Clenching		
Cancer (Type:_____)			Low Blood Pressure			Tuberculosis (TB)		
Chemotherapy/Radiation			Lung Disease			Ulcers/Stomach Problems		
Diabetes			Mouth Sores/Growths			Use of Tobacco		
Dry Mouth			Pain in Jaw/TMJ			Weight Loss/Gain (significant)		
Drug or Alcohol Addiction			Pacemaker			Other: (please state below)		

Other concerns: _____

For Women Only	Y	N		Y	N
Are you or could you be pregnant?			Are you nursing?		
If yes, estimated delivery date? / /			Are you taking birth control pills?		

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medications. Further, I will not hold my dentist, or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Legal Guardian's Signature:_____ **Date:** _____

Signature of Dentist/Medical History Review:_____ **Date:** _____