Cosmetic & Family Dentistry

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Patient Name: ______________________ ______________________ ___ ______________________
Last | First | MI | Preferred Name

What is your main concern today?

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Are you under medical treatment now?
Have you been hospitalized for any surgical operation in the last 5 years? If so, please explain.

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Are you pregnant? ◯ Yes ◯ No

Please list in the box below any medication(s) including non-prescription medicine, vitamins or supplements you are currently taking? If you have a list that we can make a copy of, please inform receptionist.

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Are you allergic to or have you had any reactions to the following?

- ☐ No Known Drug Allergies
- ☐ Local Anesthetics (e.g. Novacaine)
- ☐ Penicillin or any other antibiotic
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Latex Rubber

OTHER ALLERGIES

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Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you have or have you had any of the following?

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Diabetes
- ☐ Cardiac Pacemaker
- ☐ Joint Replacement or Implant
- ☐ Sexually Transmitted Disease
- ☐ Heart Problems
- ☐ Stomach Problems/Ulcers/Reflux
- ☐ Asthma
- ☐ Epilepsy/Convulsions/Seizures
- ☐ AIDS/HIV Infection
- ☐ Cancer/Chemotherapy/Radiation
- ☐ Hepatitis/Jaundice
- ☐ Respiratory Problems
- ☐ Thyroid Problems
- ☐ Stroke

Do your gums bleed while brushing or flossing? ◯ Yes ◯ No

Are your teeth sensitive to hot or cold liquids/foods? Are your teeth sensitive to sweet or sour liquids/foods? If so, which one and where?

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Do you feel pain in any of your teeth? If so, where?

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Do you have any sores or lumps in or around your mouth? If so, where?

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Do you like your smile? If no, why not?

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NOTES

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Response Date: ____/____/________