UNIQUE DENTAL CARE

Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents' names _____ Home phone _____ Cell phone _____

Mailing address _____ City _____State _____ Zip _____

E-Mail address_____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

Whom may we thank for referring you to our office? _____

Do you have any pain? _____ Do you have any esthetic concerns?_____

Do you grind your teeth or have headaches or muscles aches? _____Do you suffer from dry mouth? _____

MEDICAL HEALTH HISTORY

Do you have/have you had **any** of the following **conditions**?

- ❑ Cancer/tumor (type:_____)
- ❑ Heart problems or angina (chest pain)
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Heart Attack
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or heart valve (year of surgery:_____)
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Stroke
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Livery disease/Hepatitis (type: _____)
- ❑ Alcoholism/drug use history
- ❑ Blood transfusion
- ❑ Organ transplant
- ❑ Diabetes
- ❑ Thyroid (ie. high/low/nodules/surgery)
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition (ie. anxiety, depression, bipolar)
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS/HIV+
- ❑ Migraine headaches /frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions/surgery/trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma/COPD
- ❑ Chemotherapy
- ❑ Radiation
- ❑ Bariatric surgery/gastric bypass
- ❑ Glaucoma (type: _____)
- ❑ High Cholesterol

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Have you undergone any **surgery** or **hospitalization**?
(Please list)_____
_____
_____

Are you **allergic** to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin
- ❑ Local anesthetics ("Novocaine")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ NSAIDs (ie. Ibuprofen, Advil, Aleve)
- ❑ Aspirin
- ❑ Other:_____

Are you taking **any medications**?

- ❑ Aspirin
- ❑ Anticoagulants/blood thinners (ie. Coumadin)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin or other diabetes drugs
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine

Please list the names of all medications you are taking
_____
_____
_____
_____

Women:

- ❑ Pregnant or Nursing
- ❑ Taking hormones or contraceptives/birth control pill

Name of your physician:_____ Office phone number:_____

Do you have any other disease, condition, or problem not listed above?_____

Signature of patient (or parent): _____ Date: _____