Health Information

Patient name: ______________________________ **DOB:** ____________________

Are you currently taking any drugs and/or medications? If yes, please list. ☐ Yes ☐ No

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Are you taking a blood thinner? ☐ Yes ☐ No **If yes, please list.** ______________________

Are you under medical treatment now other than dental treatment? ☐ Yes ☐ No

If so, please explain ____

Have you ever been hospitalized, had a major operation or serious illnesses? Yes ☐ No ☐

If so, please explain____

Have you ever been told that you need to take an antibiotic prior to dental visits, due to an artificial joint, heart problems, etc.?

☐ **Yes** ☐ **No** **EXPLAIN:**______________________________________

Are you allergic to any of the following? (Please check all that apply)

☐ Anesthetics	☐ Acetaminophen	☐ Bleach	☐ Augmentin
☐ Latex	☐ Amoxicillin	☐ Aspirin	☐ Bactrim
☐ Pine Nuts	☐ Metals	☐ Sulfa	☐ Vicodin
☐ Penicillin	☐ Iodine	☐ Pain medications	☐ Ibuprofen
☐ Tetracycline	☐ Codeine		

Please include any other allergies not listed above: ______________________________

Do you, or have you ever had any of the following? (Please check all that apply)

☐ Heart attack	☐ Heart valve implants	☐ Anorexia or Bulimia	☐ Tumors or Growths
☐ Blood Transfusion	☐ Hepatitis	☐ Hemophilia	☐ Osteoporosis
☐ Stomach disease	☐ Pacemaker	☐ Dental Anxiety	☐ Smoking
☐ Tuberculosis	☐ Liver disease	☐ Depression	☐ Chewing tobacco
☐ Heart ailment or disease	☐ Mitral valve prolapse	☐ Epilepsy	☐ Dementia or Alzheimer's
☐ Asthma	☐ Artificial joint(s)	☐ Respiratory disease	☐ Sleep Apnea
☐ Drug abuse	☐ Stroke	☐ Seizures	☐ Cancer ____________
☐ Chemotherapy	☐ Diabetes	☐ Alcohol Abuse	☐ Other ____________
☐ Heart murmur	☐ Blood disease	☐ High Blood Pressure	
☐ Intestinal disease	☐ Aids or HIV	☐ Venereal disease	
	☐ Poor blood clotting		

Are you pregnant? ☐ Yes ☐ No If so, your expected due date is: ______________________

I certify that the information that I have provided is complete and accurate. I understand that it is my responsibility to notify this dental office of any changes prior to initiating any dental treatment.

Patient/Guardian Signature: ______________________________ **Date:** ________________

Provider Signature**:** ______________________________ **Date:** ________________