All Smiles NW

Patient's Name ____________________________ Birthdate__________________Today's Date _________________

Dental History

Reason for today's appointment: ☐ Examination ☐ Emergency ☐ Consultation

Do you have a specific dental problem? Please describe:____

Do you smoke or chew tobacco? ☐ Yes ☐ No

Do you currently use recreational drugs? ☐ Yes ☐ No Type and date of last use: ______________

Any sores or growths in your mouth? ☐ Yes ☐ No Explain:

Do you wear a night guard? ☐ Yes ☐ No

Do you brux, rind, or have discomfort in the jaw area? ☐ Yes ☐ No

New Patients Only

Date of last dental visit: ___________________________ Date of last x-rays: ______________________________

Previous Dentist:________________________________ Phone Number ______________________________

Medical History

Are you in overall good health? ☐Yes ☐ No

Physician's Name _________________________________ Phone Number: _____________________________

Current Medical Condition(s): ____

List of and Dates of Major Operations or Hospitalizations: ____

Blood Thinner (Coumadin, Worfarin, Plavix, etc) ☐ Yes ☐ No

bisphosphonates (Osteoporosis Medication) ☐ Yes ☐ No

Current Medications: ____

Allergies or Adverse Reactions to Medications

	Yes	No		Yes	No
Local Anesthetic	☐	☐	Penicillin	☐	☐
Codeine or other Narcotic	☐	☐	Other Antibiotics	☐	☐
Sulfa Drugs	☐	☐	Reaction to metals	☐	☐
Latex	☐	☐	Other Drugs/Sedatives	☐	☐

Please Specify ______________________________

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Hepatitis B or C	☐	☐	Cancer	☐	☐
Heart Attack	☐	☐	Hepatitis A	☐	☐	Type ______________________		
Heart Murmur	☐	☐	Asthma	☐	☐	Radiation Treatment	☐	☐
Ulcers/Acid Reflux	☐	☐	Psychiatric Care	☐	☐	Date ______________________		
AIDS/HIV Positive	☐	☐	Diabetes	☐	☐	Allergies-Seasonal	☐	☐
Venereal Disease	☐	☐	Stroke	☐	☐	Allergies Other	☐	☐
Anemia/Excessive Bleeding	☐	☐	Tuberculosis	☐	☐	Clarify ____________________		
Respiratory Disease	☐	☐	Pacemaker	☐	☐	Epilepsy or Seizures	☐	☐
Hip/Knee Replacement	☐	☐	Arthritis	☐	☐	Currently Pregnant	☐	☐
Rheumatic Fever	☐	☐	Vincent's Dx	☐	☐	Delivery Date ______________		

Do you have a medical condition that requires antibiotic treatment before dental therapy? ☐ ☐

Medical Updates & Notes

Date:_________ Note:____________________________ Date:________ Note:____________________________

Date:_________ Note:____________________________ Date:________ Note:____________________________

Date:_________ Note:____________________________ Date:________ Note:____________________________

Patient Signature:________________________________ Dr. Signature:________________________________