WESTON FAMILY DENTAL s.c.

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Patient Information

Patient Name: _____
Last *First* *MI* *(Preferred Name)*

Gender: ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Child

Social Security #: _____ Date of Birth: _____

Address: _____
Street *City* *State* *Zip Code*

Home Phone: _____ Cell: _____ Work: _____
Extension

Health Information

Medical History

- ☐ AIDS/HIV
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease/Anemia
- ☐ Blood Pressure
  - ☐ High ☐ Low
- ☐ Diabetes-Type ☐ 1 ☐ 2
  - ☐ Insulin ☐ Diet Controlled
- ☐ Dizziness
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Kidney Disease
- ☐ Liver Disease/Hepatitis A, B, C
- ☐ Malignant Hypothermia
- ☐ Mental Disorders
- ☐ Multiple Sclerosis
- ☐ Nervous Disorders
- ☐ Osteoporosis/Bone Disorders

If Yes, taken Fosomax? ☐ Yes ☐ No

- ☐ Parkinson's
- ☐ Pregnant - Date Due _____
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems/Ulcers
- ☐ Thyroid Disease
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Other: _____
- ☐ Other: _____

Dental History

- ☐ Anxiety
- ☐ Cold Sores/Herpes
- ☐ Clenching/Grinding/TMJD
- ☐ Periodontal Disease/Gum Disease
- ☐ Xerostomia (dry mouth)
- ☐ Other: _____

Have you had the following…

	Date	Pre-Medication (if any)
☐ Artificial Heart Valve	_____	_____
☐ Artificial Joint Surgery	_____	_____
☐ Brain Clot/Aneurysm	_____	
☐ Cancer	_____	
☐ Head Injuries	_____	
☐ Heart Attack	_____	
☐ Heart Surgery	_____	
☐ Pacemaker	_____	
☐ Radiation Treatment	_____	
☐ Other: _____	_____	

Allergies

- ☐ Amoxicillin/Penicillin
- ☐ Clindamycin
- ☐ Codeine
- ☐ Epinephrine
- ☐ Latex
- ☐ Sulfa
- ☐ Other: _____
- ☐ Other: _____

List of Medications

_____ _____ _____ _____

_____ _____ _____ _____

Date of Last Dental Visit: _____ Name of Previous Dentist: _____

Reason for Today's Visit: _____ How Often Does Patient… Floss_____ Brush _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. If I have change in my health, I will inform the staff.

_____ Date: _____
Signature of patient, parent or guardian