Adult Dentistry of Ballantyne

Patient Medical History

Patient Name_____ **DOB**___/___/___

Physician_____Office Phone_____ Date of Last Physical_____

Are you currently under medical treatment? Yes No
Have you ever been hospitalized for any surgical operation or illness? Yes No
Are you taking any medications including non-prescription medicine? Yes No
If yes, list medications_____
_____
What vitamins/herbs are you taking_____
_____
Do you use tobacco? Yes No
If yes, how much? _____
Do you use alcohol, cocaine or other drugs? Yes No

Are you allergic to, or have you had any reaction to:

Local Anesthetics (Novocaine)	Yes	No
Penicillin or other antibiotic _____	Yes	No
Sulfa Drugs	Yes	No
Barbiturates	Yes	No
Sedatives	Yes	No
Latex	Yes	No
Iodine	Yes	No
Codeine	Yes	No
Aspirin/NSAIDS	Yes	No
Other:_____	Yes	No
Women only: Are you pregnant or think you may be pregnant?	Yes	No
Are you taking a bisphosphonate?	Yes	No
Are you taking birth control pills?	Yes	No

Have you ever had any of the following conditions?

High blood pressure	Yes	No	Heart Disease	Yes	No	Chest Pains/Angina	Yes	No
Heart Attack	Yes	No	Pacemaker	Yes	No	Easily Winded	Yes	No
Rheumatic Fever	Yes	No	Heart murmur	Yes	No	Stroke	Yes	No
Swollen Ankles	Yes	No	Kidney Disorders	Yes	No	Hay Fever/Allergies	Yes	No
Fainting/Seizures	Yes	No	Ulcers	Yes	No	Tuberculosis	Yes	No
Asthma	Yes	No	Anemia	Yes	No	Radiation Tx	Yes	No
Low Blood Pressure	Yes	No	Emphysema	Yes	No	Glaucoma	Yes	No
Epilepsy/Convulsions	Yes	No	Current/past cancer	Yes	No	Weight Loss	Yes	No
Leukemia	Yes	No	Arthritis	Yes	No	Liver Disease	Yes	No
Diabetes	Yes	No	Aids/HIV	Yes	No	Joint Replacement	Yes	No
Respiratory Problems	Yes	No	Sexually Transmitted			Hepatitis A, B, C	Yes	No
Mitral Valve Prolapse	Yes	No	Disease	Yes	No	Frequent Thirst/Urination	Yes	No

Patient Dental History

Do your gums bleed while brushing or flossing?	Yes	No	Do you have frequent headaches?	Yes	No
Are your teeth sensitive to hot or cold?	Yes	No	Do you clench or grind your teeth?	Yes	No
Are your teeth sensitive to sweet or sour?	Yes	No	Do you bite your lips or cheeks frequently?	Yes	No
Do you feel pain in any of your teeth?	Yes	No	Do you snore or been told you snore?	Yes	No
Do you have any sores or lumps in or around your mouth?	Yes	No	Have you had orthodontics (braces)?	Yes	No
Have you had a head, neck or jaw injury?	Yes	No	Have you ever had prolonged bleeding after an extraction?	Yes	No
Have you ever experienced any of the following problems in your jaw?			Have you ever had instructions on brushing and flossing techniques?	Yes	No
a) Clicking	Yes	No	Have you ever had sleep apnea testing?	Yes	No
b) Pain (joint, ear, side of face)	Yes	No	Are you happy with the appearance of your teeth?	Yes	No
c) Difficulty in opening and closing?	Yes	No	Do you feel tired after full night's sleep?	Yes	No
d) Difficulty in chewing?	Yes	No			
Have you ever been required to take antibiotics prior to dental treatment ?	Yes	No			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge, and that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature_____ Date_____