DENTAL ASSOCIATES OF ST. PAUL

DENTAL ASSOCIATES OF SAVAGE

Medical History

Patient's name_____Birthdate_____SSN_____

Cell phone_____Home phone_____Work phone_____

If minor, parent(s) name_____

Legal Guardian/Caregiver_____Phone_____

Mailing address_____City_____State_____Zip_____

Additional Contact Name_____Phone_____

Pharmacy Information_____

Whom may we thank for referring you to our office?

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you currently under care of a physician? ❑ yes ❑ no

If yes, explain_____

Physician Name/ Clinic Name_____Phone_____

Have you ever been hospitalized or had a major operation? ❑ yes ❑ no

If yes, explain_____

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

- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anemia-Chronic
- ❑ Angina Pectoris
- ❑ Antipsychotic Medications
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Artificial Joint
- ❑ Autism
- ❑ Cancer Type? _____
- ❑ Chemical Dependency/Alcohol/Drugs
- ❑ Congenital Heart Defect
- ❑ Coagulation Disorder
- ❑ Crohn's Disease
- ❑ Depression
- ❑ Diabetes
- ❑ Epilepsy, Seizures, or Fainting Spells
- ❑ Excessive Bleeding
- ❑ Glaucoma
- ❑ Heart Attack When?_____/ Congestive Heart Failure
- ❑ Heart Murmur *only if Premedication Required
- ❑ Heart Valve Replacement
- ❑ Hepatitis
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Mental Disorder
- ❑ Meniere's Disease (Dizziness)
- ❑ Mitral Valve Prolapse
- ❑ Organ Transplant
- ❑ Pacemaker
- ❑ Pre-Medication
- ❑ Psychiatric Care
- ❑ Radiation/Chemotherapy When? _____
- ❑ Respiratory Problems
- ❑ Rheumatic Fever or Rheumatic Heart Disease
- ❑ Rheumatism
- ❑ Shingles
- ❑ Spina Bifida
- ❑ Stomach Problems
- ❑ Stroke When? _____
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease/ STD's

List any **Medications** you are currently taking: _____

_____

Any disease or condition not listed above? ❑ yes ❑ no

If yes, please explain_____

Are you **Allergic**, or have you reacted adversely to any of the following?
❑ Acrylic ❑ Aspirin ❑ Codeine ❑ Latex ❑ Local Anesthetics ❑ Metal ❑ Penicillin ❑ Sulfa Drugs
❑ Tetracycline ❑ Other_____

Do you smoke or use chewing tobacco? ❑ yes ❑ no
If yes, please explain_____

Do you use controlled substances? ❑ yes ❑ no
If yes, please explain_____

Are you currently taking any of the following Bisphosphonates?
❑ Fosamax ❑ Actonel ❑ Boniva ❑ Aredia ❑ Zomata

Women: Pregnant? ❑ yes ❑ no
Expected delivery date: _____
Trying to get pregnant? ❑ yes ❑ no
Nursing ❑ yes ❑ no
Taking hormones or contraceptives ❑ yes ❑ no

Dental History

Reason for today's visit? _____

Are you experiencing any dental pain today? ❑ yes ❑ no

If yes, explain_____

Previous Dentist Name/Clinic Name_____

Date of last: Dental Visit_____Radiographs_____Cleaning_____

Have you ever been told you require antibiotics before dental appointments? ❑ yes ❑ no

If yes, explain_____

Do you experience:

Dry Mouth ❑ yes ❑ no
Sensitive teeth ❑ yes ❑ no
To what? ❑ hot ❑ cold ❑ pressure ❑ sweets
Sore or bleeding gums ❑ yes ❑ no
Cold sores/ blisters/ oral lesions ❑ yes ❑ no
Loose Teeth ❑ yes ❑ no
Jaw pain or noise ❑ yes ❑ no

Comments:

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing the incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

****Signature of Patient (parent if minor or legal Guardian: _____Date_____**

Updated
****Signature of Patient (parent if minor or legal Guardian): _____Date_____**
****Signature of Patient (parent if minor or legal Guardian): _____Date_____**