CONFIDENTIAL PATIENT INFORMATION **DATE:_____**

PATIENT'S NAME: _____

DOB:_____PHARMCAY NAME:_____PHARMACY PHONE:_____

PHYSICIAN_____OFFICE PHONE_____DATE OF LAST EXAM_____

PATIENT MEDICAL HISTORY	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?		
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?		
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?		
4. IF YES, WHAT MEDICATION(S) ARE YOU TAKING?_____		
5. DO YOU USE TOBACCO? SMOKING?		
6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?		
7. ARE YOU WEARING CONTACT LENSES?		

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?	YES	NO
1. LOCAL ANESTHETICS (EG. NOVOCAINE)		
2. PENICILLIN OR OTHER ANTIBIOTICS		
3. SULFA DRUGS		
4. LATEX		
5. SEDATIVES/ BARBITURATES		
6. IODINE		
7. ASPIRIN		
8. OTHER:_____		

COMMENT(OFFICE USE ONLY)

WOMAN ONLY:	YES	NO
1. ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?		
2. ARE YOU NURSING?		
3. ARE YOU TAKING BIRTH CONTROL PILLS?		

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE			HEART DISEASE			CHEST PAINS		
HEART ATTACK			CARDIAC PACEMAKER			BLEEDING DISORDER		
RHEUMATIC FEVER			HEART MURMUR			STROKE		
SWOLLEN ANKLES			ANGINA			HAY FEVER/ ALLERGIES		
FAINTING / SEIZURES			HEART PROSTHESIS			TUBERCULOSIS		
ASTHMA			ANEMIA			RADIATION THERAPY		
LOW BLOOD PRESSURE			EMPHYSEMA			GLAUCOMA		
EPILEPSY / CONVULSIONS			CANCER			RECENT WEIGHT LOSS		
LEUKEMIA			ARTHRITIS			LIVER DISEASE		
DIABETES			JOINT REPLACEMENT / IMPLANT			FREQUENTLY TIRED		
KIDNEY DISEASES			HEPATITIS / JAUNDICE			RESPIRATORY PROBLEMS		
AIDS OR HIV INFECTION			SEXUALLY TRANS. DISEASE			BEHAVIORAL PROBLEMS		
THYROID PROBLEMS			STOMACH TROUBLES / ULCERS			OTHER:		

PATIENT DENTAL HEALTH	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?		
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?		
3. DOES YOUR WATER HAVE FLUORIDE IN IT?		
4. DO YOU FEEL PAIN IN ANY OF YOUR TEETH?		
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?		
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?		
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING? PAIN? DIFFICULTY IN OPENING OR CLOSING? DIFFICULTY IN CHEWING?		
8. DO YOU HAVE FREQUENT HEADACHES?		
9. DO YOU CLENCH OR GRIND YOUR TEETH?		
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?		
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?		
12. HAVE YOU HAD ANY ORTHODONTIC WORK?		
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?		
14. HAVE YOU EVER HAD INSTRUCTIONS ON THE CORRECT METHOD OF BRUSHING?		
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?		
16. DO YOU FLOSS DAILY?		
17. DO YOU BRUSH AT LEAST TWICE A DAY?		
18. ARE YOU INTERESTED IN POWER-LIGHT BLEACHING OR ANY OTHER COSMETIC TREATMENT?		

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information may be dangerous to my health.

_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN OF MINOR DATE

SIGNATURE OF THE DOCTOR OR SECRETARY DATE