**Please circle (Y) for “yes” or (N) for “no” for any of the following which may apply to you now or in the past:**

|  |  |  |  |
| --- | --- | --- | --- |
| Y N Heart attack / Chest Pain | Y N Implant or Artificial Joint | Y N Thyroid Disease | Y N Headaches or Migraines |
| Y N Heart Disease | When? \_\_\_\_\_\_\_\_\_\_\_\_\_ | Y N Asthma | Y N Epilepsy or Seizures |
| Y N Pacemaker | Y N Anemia or Blood Disorder | Y N Ulcers, Reflux, Heartburn | Y N Cancer, Chemo, Radiation |
| Y N Heart Value Disorder | Y N Excessive Bleeding | Y N Digestive Disorders | Y N Tuberculosis, Lung Problems |
| Y N Stroke | Y N Psychiatric Disorders | Y N Kidney or Liver Problems | Y N Hepatitis A B C D |
| Y N High Blood Pressure | Y N Mononucleosis | Y N Fainting or Blackouts | Y N AIDS or HIV Infection |
| Y N Diabetes | Y N Herpes | Y N Drug/Alcohol Dependency | Y N Use Tobacco? |

Y N Has your physician advised you to take antibiotics before dental treatment? Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Periodontal disease has been linked to the following, do you have any family history of:** (circle any that apply)

Heart Disease Stroke Diabetes Early-Term Birth Cancer Dementia

(Women) Are you currently pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, when are you expecting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any surgeries or been hospitalized in the last 5 years? □ Yes □ No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s name and phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any allergic reactions to an anesthetic or drug such as **penicillin, sedatives, latex, aspirin, or metals**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any drugs, medications, or vitamins you are currently taking:

We offer a variety of services to enhance your comfort, and keep your smile beautiful. Please circle any service below you would like our friendly team to discuss with you during your visit.

Whitening/Bleaching Sedation Invisalign (clear braces)

Traditional Braces Veneers Extended Payment Plans

Headache/Migraine Therapy Implants Replace Missing Teeth

Night/Sports/Snoring Appliances

Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Doctor/Hygienist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_