heber city dental

Patient Name_____ Birthdate_____

Address_____ City, State, ZIP_____

Cell phone_____ Home phone_____ SSN_____

Email_____ Employer_____

Emergency contact name_____ and phone number_____

How did you hear about our office? _____

DENTAL HISTORY

What would you like us to do today? _____

Are you in dental discomfort today?_____

Former dentist_____ Date of last dental care_____

How often do you brush?_____ Floss?_____

Have you ever experienced an adverse reaction during or in conjunction with anesthesia or a medical procedure? Y ☐ N ☐

Other information about your dental health or previous treatment_____

Have you had problems with any of the following? Check Yes or No

☐Y ☐N Bad breath	☐Y ☐N Food collection between teeth	☐Y ☐N Periodontal treatment
☐Y ☐N Bleeding gums	☐Y ☐N Grinding or clenching teeth	☐Y ☐N Sensitivity to hot
☐Y ☐N Clicking or popping jaw	☐Y ☐N Loose teeth or broken fillings	☐Y ☐N Sensitivity to cold
☐Y ☐N Sores/growths in mouth	☐Y ☐N Sensitivity to sweets	☐Y ☐N Sensitivity to biting

MEDICAL HISTORY

Physician's name_____ Date of last visit_____

Are you currently under a physician's care? ☐Y ☐N If yes, describe_____

Have you ever had a blood transfusion? ☐Y ☐N If yes, give approximate date_____

Do you have any artificial joints or heart valves? ☐Y ☐N If yes, please list_____

If yes, have you been advised to pre-medicate with an antibiotic for dental work? _____

Have you ever used a bisphosphonate medication? (Fosamax, Actonel, Atelvia, Didronel, Boniva) ☐Y ☐N

Women: Are you pregnant? ☐Y ☐N Nursing? ☐Y ☐N Taking birth control pill? ☐Y ☐N

Is patient currently taking any medications? ☐Y ☐N If yes, list all in the space below.

Does patient have any drug allergies? ☐Y ☐N If yes, please list medications and the allergic reaction.

_____

Does patient have any allergy to anesthetic or epinephrine? ☐Y ☐N_____

Check Yes or No whether you have had any of the following:

☐Y ☐N AIDS/HIV Positive	☐Y ☐N Fainting	☐Y ☐N Psychiatric Care
☐Y ☐N Anaphylaxis	☐Y ☐N Food allergies	☐Y ☐N Rapid weight loss/gain
☐Y ☐N Anemia	☐Y ☐N Glaucoma	☐Y ☐N Radiation treatment
☐Y ☐N Arthritis/ Rheumatism	☐Y ☐N Headaches	☐Y ☐N Respiratory disease
☐Y ☐N Artificial heart valves	☐Y ☐N Heart murmur	☐Y ☐N Rheumatic/ Scarlet fever
☐Y ☐N Artificial joints	☐Y ☐N Heart problems	☐Y ☐N Shingles
☐Y ☐N Asthma	If yes, describe	☐Y ☐N Shortness of breath
☐Y ☐N Atopic/ Allergy prone	☐Y ☐N Hemophilia/bleeding	☐Y ☐N Skin rash
☐Y ☐N Back problems	☐Y ☐N Herpes	☐Y ☐N Spina bífida
☐Y ☐N Blood disease	☐Y ☐N Hepatitis	☐Y ☐N Stroke
☐Y ☐N Cancer	☐Y ☐N High blood pressure	☐Y ☐N Surgical implant
☐Y ☐N Chemical dependency	☐Y ☐N Jaw pain	☐Y ☐N Swelling of feet or ankles
☐Y ☐N Chemotherapy	☐Y ☐N Kidney disease	☐Y ☐N Thyroid disease
☐Y ☐N Circulatory problems	☐Y ☐N Liver disease	☐Y ☐N Tobacco habit
☐Y ☐N Cortisone treatments	☐Y ☐N Material allergies	☐Y ☐N Tonsilitis
☐Y ☐N Cough-persistent	(latex, wood, metals, chemicals)	☐Y ☐N Tuberculosis
☐Y ☐N Cough up blood	☐Y ☐N Mitral valve prolapse	☐Y ☐N Ulcer/ Colitis
☐Y ☐N Diabetes	☐Y ☐N Nervous problems	☐Y ☐N Venereal disease
☐Y ☐N Epilepsy	☐Y ☐N Pacemaker/ heart surgery	☐Y ☐N Other—describe below

Notes:

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate dental treatment. If there is any change in my medical status, I will inform the dentist. I consent to have Heber City Dental provide me with dental treatment.

Signature of patient:_____ Date _____

Signature of dentist: _____ Date _____