Dental Health Update

Name: _____ **Date of Birth:** _____

Mailing Address: _____ **City:** _____ **Zip:** _____

Phone: Home _____ **Cell** _____ **Work** _____

Email Address _____ **Dental Insurance Company Name** _____

Reason for today's visit _____ **How often do you brush?** _____ **How often do you floss?** _____

Please circle any of the following conditions that apply to you:

Acid Taste in Mouth	Food collection between teeth	Clicking or popping jaw
Bad Breath	Grinding teeth	Sensitivity to hot
Bleeding gums	Loose teeth or broken filling	Sensitivity to sweets
Belching	Periodontal treatment	Sensitivity when biting
Heartburn	Sensitive to cold	Sores or growths in your mouth
Vomiting	Sore throat	Excess Salivation
Sense of lump in throat	Choking Spells	Hoarseness of voice Dry mouth

Medical History:

Physician: _____ **Date of last visit** _____

Please list all medications you are currently taking: _____

_____

Allergies: Medication or food: _____ **Dental Anesthetics**

Aspirin Erythromycin Tetracycline Tomatoes Codeine Latex Kiwis Potatoes

Penicillin Amoxicillin Chestnuts Bananas Avocados Sulfa Hazelnuts Peanuts

***** Are you taking any of these Medications: Fosamax Actenel Bonenva Zometa?**

Do you have any of the following? *(Please Circle all that apply)*

			Osteoporosis
AIDS/HIV /ARC	Cortisone Treatments	Hepatitis	Rheumatic Fever
Anemia	Cough Persistent	High Blood Pressure	Scarlet Fever
Arthritis, Rheumatism	Cough up blood	Jaw Pain	Skin Rash
Artificial Heart Valves	Diabetes	Kidney Disease	Shortness of breath
Congenital Heart Problem	Spina Bifida	Heart Attack	
Artificial Joints	Epilepsy	Liver Disease	Stroke
Asthma	Fainting	Mitral Valve Prolapse	Thyroid Problem
Back problems	Glaucoma	Nervous Problems	Tobacco Habit
Blood Disease	Headaches	Pacemaker	Tonsillitis
Cancer/ Chemotherapy	Heart Murmur	Psychiatric Care	Tuberculosis
Chemical Dependency	Heart Trouble	Radiation Treatment	Ulcer
Circulatory Problems	Describe_____	Drug/alcohol addiction	Venereal Disease
Hemophilia	Respiratory Disease		

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Authorization:

I certify that I 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 can be dangerous to my health. I hereby authorize Dr. Sutton and the entire staff to administer any treatment including x-rays and anesthetics and to perform such dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental or my dependents dental condition. I understand the use of anesthetic agents embodies a certain risk.

_____

Signature of Patient or Parent **Date**