Watkins
FAMILY DENTAL

Patient Name _____ Preferred Name_____

1. Are you under any medical treatment now?
   _____
2. Physician name_____
3. Physician phone #_____
4. Date of last medical exam_____
5. Have you been hospitalized for any surgical operations or serious illness within the last 5 years? _____ (If yes, please explain)
   _____
6. Are you taking any medications including non-prescription medicine?_____ Please list any medications you are taking_____
   _____
   _____
7. Do you take any blood thinners or an aspirin daily?_____Please list _____
8. Have you ever taken Fen-Phen/Redux? _____When?_____
9. Have you ever taken Fosamax, Bonita, Actonel or any cancer medications containing bisphosphonates? _____ When?_____
10 Do you require antibiotics prior to dental treatment?_____
   If so why?_____
11. Do you use tobacco?_____ If yes, what type?_____
12. Do you use controlled substances?_____Explain_____

13. Are you allergic too or have you had any reactions to the following?
    1. Local Anesthetics (e.g. Novocaine) Y N
    2. Penicillin or any other Antibiotics Y N
    3. Sulfa Drugs Y N
    4. Iodine Y N
    5. Any Metals(e.g. nickel, mercury, etc.) Y N
    6. Latex Rubber Y N
    7. Other _____

Women only

Are you pregnant or think you may be pregnant? *Y* *N*
Are you nursing? *Y* *N*
Are you taking oral contraceptives? *Y* *N*

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Patient Name_____ Preferred Name_____

Do you have any of the following?

Congenital Heart	Y	N	Seasonal Allergies	Y	N
Disease	Y	N	Epilepsy	Y	N
Heart Murmur	Y	N	Seizures/Convulsions	Y	N
Rheumatic Fever	Y	N	Numbness or Tingling	Y	N
Mitral Valve Prolapse	Y	N	Fainting/Dizziness	Y	N
Heart Attack	Y	N			
Irregular Heart Beat	Y	N	Diabetes (Type I or II)	Y	N
Angina/Chest Pain	Y	N	Thyroid Problems	Y	N
Heart Surgery	Y	N			
Artificial Heart Valve	Y	N	Bleeding/Bruising	Y	N
Heart Pace Maker	Y	N	Easily	Y	N
High Blood Pressure	Y	N	Blood Disorder	Y	N
Low Blood Pressure	Y	N	Anemia	Y	N
Stroke/Paralysis	Y	N	Immune System	Y	N
Swollen Ankles	Y	N	Problems		
Fainting/Seizures	Y	N	(Lupus,		
			Immunodeficiency,		
Asthma	Y	N	Sjogrens)		
Shortness of Breath	Y	N			
Emphysema	Y	N	AIDS or HIV infection	Y	N
Shortness of Breath	Y	N	Herpes	Y	N
Oxygen Dependent	Y	N	Hepatitis (A, B, C or	Y	N
Persistent Cough	Y	N	D)	Y	N
Sleep Apnea	Y	N	STDs_____	Y	N
Snoring	Y	N			
Asthma	Y	N	Rheumatism/Arthritis	Y	N
Tuberculosis	Y	N	Artificial Joint	Y	N
			Osteoporosis	Y	N
Kidney Disease	Y	N			
Liver Disease	Y	N	Current Cancer	Y	N
Stomach/Intestinal			Past Cancer	Y	N
Disease	Y	N	Radiation Therapy	Y	N
Ulcers	Y	N	Chemotherapy	Y	N
GERD(acid reflux)	Y	N	Year_____	Remission _____	

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Name of Previous Dentist and Location _____Date of Last Exam _____

1.	Are you in any pain today?	Y	N
2.	Do your gums bleed while brushing or flossing?	Y	N
3.	Are your teeth sensitive to hot or cold liquids or foods?	Y	N
4.	Are your teeth sensitive to sweet or sour liquids or foods?	Y	N
5.	Do any of your teeth hurt?	Y	N
6.	Are any of your teeth sensitive to pressure?	Y	N
7.	Do you have any sores or lumps in or near your mouth?	Y	N
8.	Have you had any head, neck or jaw injuries?	Y	N

9. Have you ever experienced any of the following problems with your jaw?

Clicking	Y	N
Pain (joint, ear, side of face)	Y	N
Difficulty in opening or closing	Y	N
Difficulty in chewing	Y	N
Do you have frequent headaches?	Y	N
Do you clench or grind your teeth?	Y	N

10. Have you ever had any difficult extractions in the past?	Y	N
11. Have your ever had any prolonged bleeding following extractions?	Y	N
12. Have you had orthodontic treatment?	Y	N
13. Would you be interested in orthodontic treatment?	Y	N
14. Do you wear dentures or partials?	Y	N
If yes, date of placement _____		
15. Do you suffer from dry mouth?	Y	N
16. Do you like your smile?	Y	N
Is there anything you would like to change? _____		

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 can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient (or parent/guardian if minor) Please print name