PATIENT NAME: _____ **DATE OF BIRTH: ____/____/____**

Medical Information: Primary Care Physician: Dr._____ Phone #: (_____)_____-_____
Date of last PCP visit: ____/____/____ Current physical health: □Good □Fair □Poor
Are you currently under the care of a physician? □Yes □No
If yes, explain reason. _____
_____
Are you taking any medications? □Yes □No
If yes, please list each one: _____
_____

Have you ever taken Bisphosphonates? □Yes □No If so, date last taken____/____/____ Currently? □Yes □No

For Women: Are you taking birth control pills? □Yes □No /Are you nursing? □Yes □No / Are you pregnant? □Yes □No / Week#____

IT IS IMPORTANT THAT YOU ALERT US TO ALL OF YOUR MEDICAL CONDITIONS

Have you ever had any of the following medical conditions? *(Please circle Y or N for each)*

Y N Abnormal Bleeding
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial bones or joints
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Colitis
Y N DENTAL ANXIETY
Y N Diabetes
Y N Emphysema
Y N Epilepsy/Seizures
Y N Fever Blisters
Y N Frequent Headaches
Y N Glaucoma
Y N Heart Murmur
Y N Heart Trouble
Y N Hemophilia
Y N Hepatitis
Y N High Blood Pressure
Y N HIV+/Aids
Y N Kidney Problems
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic Fever
Y N Shingles
Y N Sinus Problems
Y N Thyroid Condition
Y N Tobacco Use (_____ a day)
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease
Y N Sleep Apnea
Y N Snoring
Y N Daytime Fatigue
Y N Other _____

Are you allergic to any of the following? *(Please circle Y or N for each)*

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Sulfa Drugs
Y N Tetracycline
Y N Other_____

Have you returned from a foreign country within the last 30 days? □Yes □No Are you experiencing flu-like symptoms? □Yes □No
Dental History: Why have you come to the dentist today? _____
Are you interested in **Sedation** for dental work? _____
Previous / Present Dentist: _____ Date of last visit: _____
Have you ever had a serious / difficult problem associated with any previous dental work? □Yes □No If yes, please explain:
_____
Your current dental health is? □Good □Fair □Poor Do you like your smile? □Yes □No
Your toothbrush bristles are? □Hard □Medium □Soft Do your gums ever bleed? □Yes □ No
How often do you brush? _____ / floss? _____

I understand, in accordance with Section 32.1-45.1 of the Code of Virginia, 1950, as amended, that if the provision of health care services to the patient at this office directly exposes any person by or under the direction and control of the health care provider to the patient's body fluids in a manner which may transmit immunodeficiency virus or HIV, then the patient shall be deemed to have consented to testing for infection with HIV and to the release of such tests results to the persons exposed.

AUTHORIZATION: I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I authorize the dental team to perform any necessary dental services, with my informed consent, that I may need during diagnosis and treatment.
Signature: _____ **Date**: ____/____/____

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MIDLOTHIAN FAMILY DENTISTRY USE ONLY:

I verbally reviewed the medical / dental information above with the patient named herein.

Initials _____ Date____/____/____ **PATIENT ID NO. _____**