

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

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

- | | | |
|------------------------|------------------|------------------|
| Y N Aspirin | Y N Erythromycin | Y N Sulfa Drugs |
| Y N Codeine | Y N Latex | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Penicillin | 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: ____/____/____

MIDLOTHIAN FAMILY DENTISTRY USE ONLY:

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

Initials _____

Date ____/____/____

PATIENT ID NO. _____