

MEDICAL-DENTAL PROFILE

PATIENT NAME Mr Mrs Ms Dr _____ **Date of Birth** _____ **Today's Date** _____

HOW WOULD YOU PREFER TO BE ADDRESSED? _____ **OCCUPATION** _____

PHYSICIAN _____ Town _____ or Office Phone _____

Approximate date of last **COMPLETE PHYSICAL EXAM** _____

HOSPITALIZATIONS OR SURGERIES within the past 6 months _____

Approximate date of last **DENTAL CHECKUP** _____

MEDICATIONS: Please list **medicines** you take and the **conditions** for which you take them (prescription, non-prescription, supplements, vitamins) _____

Are you taking or have you ever taken **Bisphosphonates** (Fosamax, Actonel, etc. to treat osteoporosis/osteopenia)? YES NO

ALLERGIES: (please circle) Penicillin Codeine Novocaine Latex Other (please list) _____

Do you play **SPORTS?** YES NO If YES, do you wear an athletic **MOUTHGUARD?** YES NO

WOMEN: Are you **Pregnant?** YES NO Are you **Nursing?** YES NO Are you taking **Birth Control Pills?** YES NO

Do any of the following conditions apply or have they in the past applied to you? (Circle YES or NO)

YES NO Arthritis	YES NO Heart Defect
YES NO Artificial Heart Valve	YES NO Heart Disease – Heart Attack or Angina
YES NO Artificial Hip, Knee or Shoulder Joint	YES NO High Blood Pressure
YES NO Asthma	YES NO Hepatitis A B C
YES NO Blood Disorder – Prolonged Bleeding	YES NO Kidney Disease
YES NO Cancer	YES NO Lung Disease
YES NO Chronic Obstructive Pulmonary Disorder	YES NO Oral Herpes / Cold Sores
YES NO Compromised Immune System (AIDS, HIV+)	YES NO Osteoporosis or Osteopenia
YES NO Diabetes	YES NO Pacemaker
YES NO Eating Disorder (Anorexia or Bulimia)	YES NO Premedication Before Dental Treatment
YES NO Emphysema	YES NO Radiation Therapy to the Head and Neck
YES NO Epilepsy or Seizures	YES NO Stroke
YES NO Fainting Spells	YES NO Thyroid Problems
YES NO Head Injuries	YES NO Tuberculosis

Please answer the following questions: (circle Yes or No)

YES NO Are you currently wearing partial or full **DENTURES** or do you have any dental **IMPLANTS?**

YES NO Do you **SMOKE** or **CHEW TOBACCO?**

YES NO Do you have a history of **Excessive Alcohol Consumption** or **Substance Abuse?**

YES NO Have you ever used **Fen-phen** (or other prescribed diet medicines)?

YES NO Have you ever had a **BAD REACTION** to **NOVOCAINE** for dental procedures?

YES NO Do you suffer from **TMJ DYSFUNCTION** (jaw pain)

YES NO Do your jaws ever feel **TIRED** because you **GRIND** or **CLENCH** your teeth?

YES NO Do your **GUMS BLEED** when you brush, floss or use a toothpick?

YES NO Are your gums **RED, SWOLLEN, TENDER** or **RECEDING?**

YES NO Do you suffer from persistent **BAD BREATH?**

YES NO Do you **BRUSH** your teeth at least **TWICE** a day?

YES NO Are you using a **SOFT-BRISTLED** toothbrush?

YES NO Do you **FLOSS** your teeth at least **ONCE** a day?

YES NO Do you **CLEAN YOUR TONGUE?**

YES NO Are you happy with your **SMILE?**

Please list any other **medical** or **dental** conditions, information or concerns you may have: _____

I certify that, to the best of my knowledge, the above "Protected Health Information" is truthful, accurate and complete. I authorize the release of this information as well as exam, diagnosis and treatment records of services rendered to me to third party payers and/or health practitioners as is necessary. I acknowledge that this office is in compliance with HIPAA Privacy Regulations and that a copy of their Privacy Practices Notice is available to me upon request at any time.

Patient Signature (or Representative)X _____ Relationship to patient _____ Date _____