Ultimate Dental STUDIO

Patient History; please print and complete in detail, use the back side if needed.

Today's Date: ____________________ DOB: ______________ Age: ________________

Last Name, First Name:________________________________ Preferred Name____________________

Street Address: ____________________________________ City, ST, Zip ______________________

Height: ________Weight: _________ Social Security #: ______________________________________

Occupation: _________________________________ Spouses Name (if married): __________________

Cell number:_______________________ May we send text appointment reminders? yes no

Work Number_______________________ Home Number___________________________

e-mail address: _________________________________ May we send email appointment reminders? yes no

Date of last Dental Visit/ Dentist Name: ____

What is your present dental problem?____

Are you having any discomfort or pain and if so, where? _______________________________________

Who may we thank for referring you? ____

Name of medical doctor: ___________________________ Are you interested in whitening your teeth? Yes No

In the following questions, circle yes or no. Your answers are confidential.

• Do you have or have you had any of the following diseases or problems (Circle appropriate ones)

Heart Trouble, rheumatic fever, high or low blood pressure, thyroid, stomach ulcer, asthma, sinusitis, diabetes, epilepsy, tuberculosis, kidney or liver involvement, joint problems, anemia, hysterectomy, blood disorders, cancer, eye problems?

• Are you now under the care of a physician Yes No

• Have you had serious illness or operations? Yes No

• Have you used tobacco products? Yes No

• Have you had an organ transplant? Yes No

• Have you ever had radiation or X-ray therapy? Yes No

• Do you have a heart murmur? Yes No

• Have you had an artificial joint replacement? Yes No

• Do you excessively bleed, or bruise or swell easily? Yes No

Are you taking any of the following:

• Antibiotic or Sulfa drugs Yes No

• Anticoagulants (blood thinner) Yes No

• Medicine for high blood pressure Yes No

• Cortisone (steroids) Yes No

• Aspirin Yes No

• Insulin or any drug for treatment of diabetes Yes No

• Digitalis, nitroglycerin, or drugs for heart trouble Yes No

****PLEASE NOTE: Antibiotics can alter the effectiveness of birth control pills****

List all medications you are currently taking by name, include all vitamins and herbal medicines:

____

List any operations: ____

Have you stopped or changed any prescription or over-the-counter medication or dietary supplement within the last year?

____

Are you allergic or have reacted adversely to:

• Local anesthetics (Novocain) Yes No

• Codeine Yes No

• Penicillin or other antibiotic **please name** Yes No ______________________________

• Aspirin Yes No

• Have you ever had hepatitis Yes No

• Other (please list) ____

• Have you had trouble with any other dental treatment you think we should know about? Yes No

• Have you ever tested positive for HIV? Yes No

• Do you have any disease, condition, or problem not listed above? Yes No

• Do you have a condition that requires medication before your dental visit? Yes No

Signed: ______________________________ Date: ______________________________

Update I: ______________________________ Date: ______________________________

Update 2:______________________________ Date: ______________________________