Dr. Stanley Altizer
COSMETIC AND FAMILY DENTISTRY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient Name: _____ DOB: _____ Patient ID: _____

Currently under the care of a physician? ___Yes ___No If yes, reason: _____

Do you require antibiotic premedication for any reason? ___ Yes ___ No

Please indicate if you are allergic to any of the following:

- ☐ Dental Anesthetic ('Novocaine')
- ☐ Amoxicillin/Penicillin
- ☐ Clindamycin/Erythromycin
- ☐ Codeine
- ☐ Latex
- ☐ Other allergy: _____
- ☐ Tetracycline
- ☐ Vicodin/Hydrocodone

Please indicate if you have any of the following medical conditions:

- ☐ AIDS/HIV+
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma/Respiratory Disease
- ☐ Bleeding Problems
- ☐ Cancer/Tumors
- ☐ Chemotherapy/Radiation
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Heart Murmur/Defect
- ☐ Hepatitis/Jaundice
- ☐ High Blood Pressure
- ☐ HPV (Human Papillomavirus)
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus/MS
- ☐ Mental/Nervous Disorder
- ☐ Pacemaker
- ☐ Pregnancy (Due: _____)
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid/Parathyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other condition(s) not listed. Please detail on line below.

_____

Tobacco user? ___Yes ___No If so, what kind and how much?_____

Do you drink more than two alcoholic drinks on a daily basis? ___Yes ___No

Admitted to a hospital or needed emergency care in the past two years? ___Yes ___No

If so, please explain: _____

If you are taking any medications (Including OTC) please complete the back of this form

Reason for today's visit: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the office at the next appointment without fail.

_____

Signature

List all medications that you are now taking, including OTC:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

So our office may better serve your dental needs, please answer the following questions:

Yes	No	
[ ]	[ ]	Are you satisfied with the appearance of your teeth? If no, what would you change?
[ ]	[ ]	Other than wisdom teeth (3rd molars), do you have any missing teeth that have not been replaced?
[ ]	[ ]	Do you clench or grind your teeth at night?
[ ]	[ ]	Do you notice clicking, tenderness, or pain in your jaws?

In the past have you had:

[ ]	[ ]	Orthodontic (braces) treatment ?
[ ]	[ ]	Oral Surgery?
[ ]	[ ]	Periodontal (gum) treatment?
[ ]	[ ]	Endodontic (root canal) treatment?

[ ]	[ ]	Are there any concerns or conditons not mentioned previously that our office should be aware of? If so, please list:

_____

_____

_____