MINSTER DENTAL CARE

NEW PATIENTS:

Reason for today's visit: _____

Former Dentist: _____ City/ State: _____

Reason for leaving: _____

Last dental visit: _____ Last cleaning: _____ Last x-rays: _____

If minor, has child ever been in the hospital? Yes / No If yes, Why? _____

If minor, has child ever been to the ER? Yes / No If yes, Why? _____

If minor, has child had any unfavorable experiences in a dental / medical office? Yes / No _____

Any significant concerns regarding this child's medical / dental history? Yes / No _____

CHECK All That Apply:

□ Bad Breath	□ Food collecting between teeth	□ Piercings- Tongue and/or lip
□ Bleeding Gums	□ Grinding teeth	□ Sensitivity to cold
□ Blisters on lips or mouth	□ Gums swollen or tender	□ Sensitivity to heat
□ Burning sensation on tongue	□ Jaw pain or tiredness	□ Sensitivity to sweets
□ Chew on side of mouth	□ Lip or cheek biting	□ Sensitivity when biting
□ Chew tobacco	□ Loose teeth / broken fillings	□ Smoking- cigarette, pipe, cigar
□ Clicking or popping jaw	□ Mouth breathing	□ Sores/growth in mouth
□ Dry Mouth	□ Mouth pain with brushing	□ Thumb / finger sucking
□ Fingernail / lip biting	□ Orthodontic treatment	
□ Fluoride supplements	□ Pacifier	How often do you floss? _____
□ Fluoride rinse	□ Pain around ear	How often do you brush? _____
□ Fluoridated water	□ Periodontal treatment	

Minster Dental Care Health History

PATIENT NAME: _____

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

Are you under a physician's care now?	Y / N	If yes, why:
Have you have been hospitalized or had a major operation?	Y / N	If yes, why:
Have you ever had a serious neck injury?	Y / N	If yes, why:
Are you taking any medications, pills, or drugs?	Y / N	If yes, why:
Do you require pre-medication or antibiotics prior to dental procedure?	Y / N	If yes, why:
Do you take, or have you taken, Phen-Fen or Redux?	Y / N	If yes, why:
Have you ever taken Dosamaz, Boniva, Actonel, or any other medication containing bisphosphonates?	Y / N	If yes, what:
Do you use tobacco?	Y / N	If yes, what:
Do you use controlled substances:	Y / N	If yes, what:

Woman: Are you…

□ Pregnant or trying to become? □ Nursing? □ Taking Oral Contraception?

Are you allergic to any of the following? *(Check all that apply)*

□ Aspirin □ Penicillin □ Codeine □ Acrylic
□ Metal □ Latex □ Sulfa Drugs □ Local Anesthesia

OTHER:

CHECK All That Apply:

□ AIDS/HIV □ Cortisone Medicine □ Hemophilia □ Radiation Treatment
□ Alzheimer's Disease □ Diabetes □ Hepatitis A □ Recent Weight Loss
□ Anaphylaxis □ Drug Addiction □ Hepatitis B or C □ Renal Dialysis
□ Anemia □ Easily Winded □ Herpes □ Rheumatic Fever
□ Angina □ Emphysema □ High Blood Pressure □ Rheumatism
□ Arthritis/Gout □ Epilepsy or Seizures □ High Cholesterol □ Scarlet Fever
□ Artificial Heart Valve □ Excessive Bleeding □ Hives or Rash □ Shingles
□ Artificial Joint □ Excessive Thirst □ Hypoglycemia □ Sickle Cell Disease
□ Asthma □ Fainting/Dizziness □ Irregular Heartbeat □ Sinus Troubles
□ Blood Disease □ Frequent Cough □ Kidney Problems □ Spina Bifida
□ Blood Transfusions □ Frequent Diarrhea □ Leukemia □ Stomach/GI Issues
□ Breathing Problems □ Frequent Headaches □ Liver Disease □ Stroke
□ Bruise Easily □ Genital Herpes □ Low Blood Pressure □ Swelling of Limbs
□ Cancer □ Glaucoma □ Lung Disease □ Thyroid Disease
□ Chemotherapy □ Hay Fever □ Mitral Valve Prolapse □ Tonsillitis
□ Chest Pains □ Heart Attack/Failure □ Osteoporosis □ Tuberculosis
□ Cold Sores/Fever Blisters □ Heart Murmur □ Pain in Jaw Joint □ Tumors or Growths
□ Congenital Heart Disorder □ Heart Pacemaker □ Parathyroid Disease □ Ulcers
□ Convulsions □ Heart Trouble/Disease □ Psychiatric Care □ Venereal Disease
□ Yellow/Jaundice □ Brain Damage □ Circulatory Problems □ Parkinson's Disease

Have you ever had any serious illness not listed above? If yes, what:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Minster Dental Care of any changes in medical status.

✖ _____ _____

Signature of Patient (over 18) Or Parent / Guardian Date