Lacey Family Dental **health**

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only, and will be kept confidential subject to applicable laws. Please note that you may be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient __________________________ Date ______________

Are you in good health?	Yes / No
Have you had a serious illness, operation, or hospitalization in the past five years?	Yes / No
If yes, please describe:	
Have you ever been told you need to regularly take antibiotics before dental treatment?	Yes / No
Have you ever had a joint replacement?	Yes / No
If so, when and describe any complications?	
Have you ever taken Fosamax, Zometa, Aredia, Boniva or any other oral or intravenous bisphosphonates (used for osteoporosis)?	Yes / No When?
Are you pregnant or nursing?	Yes / No

Circle below if you are allergic to:
Local anesthetics ("Novocaine") ……………………………...
Latex ………………………………………………………..
Penicillin or other antibiotics ………………………………….
Aspirin ……………………………………………………...
Sulfa drugs …………………………………………………….
Codeine or other narcotics …………………………………….
Metals ………………………………………………………….
Hay fever/seasonal …………………………………………….
Other (specify) ………………………………………………...

Please list your prescriptions, over-the-counter medications, vitamins, natural/herbal preparations, and/or supplements:
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Please list any significant medical conditions, for example: Hepatitis, HIV, TB, Epilepsy, High Blood Pressure, Asthma, Endocarditis, Heart/Valve issues, Stroke, Cancer, Diabetes...
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What is your chief dental concern? ________________
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When was your last dental treatment? ______________

Please check any of the following that concern you:

___ Teeth sensitive to cold, heat, sweets, pressure, or biting
___ Painful teeth or gums
___ Bleeding gums
___ Tooth decay (cavities or "caries")
___ Missing teeth / gaps or spaces
___ Crooked teeth
___ Teeth too yellow
___ Teeth chipped or fractured
___ Clenching or grinding
___ Wisdom teeth
___ Food impaction between teeth
___ Swelling or lumps in mouth
___ Frequent sores on lips or in mouth
___ TMJ (jaw joint) treatment or issues
___ Pain around ear or jaw
___ Bad breath ("halitosis") / unpleasant taste in mouth
___ Complications from extractions
___ Periodontal (gum) treatment
___ Orthodontic treatment
___ Mouth breathing / trouble breathing through nose
___ Tobacco consumption
___ Oral habits (i.e. nail biting, cheek biting, etc.)
___ Previous bad dental experiences
___ Dental fear / anxiety

Anything else you'd like to discuss with us?
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To the best of my knowledge, all of the information provided is complete and accurate. I will inform my dentist of any changes.

Patient/Guardian's Signature ____ Date _________________________