

If you have any condition or problem not mentioned that you feel we should be aware of, please note here:

Name of General Physician _____ Phone _____

Name of Specialist _____ Phone _____

Medications

Please list all medications and their dosages that you take on a regular basis.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Do you smoke? ____yes____no Tobacco use is the most significant risk factor for gum disease. Smokers are at a 50% greater risk for tooth loss. If you do smoke, how many packs/day? _____

Has fear ever been an issue for you in the dental office? ____yes____no If yes, please be specific about what makes you nervous or fearful _____

"I understand that the information I have provided on this form is essential to determine my dental needs and to provide proper dental treatment. I understand that if any change in my health occurs, I am to inform this office at my next scheduled appointment so that my medical history can be updated. I understand each question and have answered each of them truthfully and to the best of my ability."

Signature

Date