

# Dehnert Dental

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Last Dental Visit: \_\_\_\_\_ Reason for today's visit: \_\_\_\_\_

Change in address: \_\_\_\_\_

Current phone number: \_\_\_\_\_ Email address: \_\_\_\_\_

Have you ever had any history of Temporal Mandibular Joint Disease? ☐ No ☐ Yes

Have you ever had any discomfort in your Temporal Mandibular Joint? ☐ No ☐ Yes

Are you now or have you ever been, a smoker? ☐ No ☐ Yes If so, how much? \_\_\_\_\_ when did you quit? \_\_\_\_\_

## Health Information

Have you ever had any of the following?

Please check those that apply:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tumors                   |
| <input type="checkbox"/> Latex Allergy      | <input type="checkbox"/> Excessive Bleeding     | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Taken Xarelto or Eliquis |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Pregnancy            | in the last 24 hours.                             |
|   | <input type="checkbox"/> Hay Fever              | Due date: _____                               | <input type="checkbox"/> Untreated Ulcers         |
| <input type="checkbox"/> A1C test _____     | <input type="checkbox"/> Head Injuries          | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Venereal Disease         |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Heart Disease/Problems | <input type="checkbox"/> Respiratory Problems |   |
| <input type="checkbox"/> Artificial Joints  | <input type="checkbox"/> Heart Murmur           | <input type="checkbox"/> Rheumatic Fever      | OTHER:  |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> _____                    |
| <input type="checkbox"/> Bleeding INR >3    | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Sinus Problems       | <input type="checkbox"/> _____                    |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Stomach Problems     |   |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Stroke               |   |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Tuberculosis         |   |

. Have you ever had any complications following dental treatment? Yes No

If yes, please explain: \_\_\_\_\_

. Have you been admitted to a hospital or had surgical treatment for any condition? Yes No

If yes, please explain: \_\_\_\_\_

. Are you now under the care of a physician? Yes No

If yes, please explain: \_\_\_\_\_

. Name of Physician: \_\_\_\_\_ Phone \_\_\_\_\_

. Do you have any health problems that need further clarification? Yes No

If yes, please explain: \_\_\_\_\_

. Are you taking any medications either over the counter or prescribed? Yes No

If yes, please list: \_\_\_\_\_

. Are you allergic to any medications? Yes No If yes, please list: \_\_\_\_\_

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 doctors at the next appointment without fail.

\_\_\_\_\_  
Date: \_\_\_\_\_

Signature of patient, parent or guardian

\_\_\_\_\_  
Date: \_\_\_\_\_

Signature of the dentist

Vital Signs: Blood pressure \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_