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

Please check those that apply:

Have you ever had any of the following?

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

OTHER:

□ _____
□ _____

. 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 _____

_____ _____ _____