

Westdale Dental, PC

Patient: _____ Birth date: ___/___/___ Age: ___ Today's date: ___/___/___

Your current physical health is: Good Fair Poor Physician's (Medical Doctor) Name: _____

Please list any prescription, over-the-counter medicines, herbal or dietary supplements currently being taken and for what conditions:

_____ to treat _____ to treat _____
_____ to treat _____ to treat _____
_____ to treat _____ to treat _____

Have you ever had or are currently experiencing any of the following diseases or medical conditions? (check all that apply)

- Checkboxes for various medical conditions: Pacemaker, Heart Attack/Stroke, High Blood Pressure, Diabetes Type, Insulin Dependent, Bleeding Disorder, etc.

Please list hospitalizations (surgeries, emergency room) within the last year: _____

Do you require any special accommodations? :

Are you allergic to any of the following? If so, indicate what kind of reaction you had:

- Checkboxes for allergies: Foods, Latex, Metals or Dental Materials, Local Anesthetics, Medicines, etc.

Dental Issues. Please indicate if you wish to discuss treatment of the following:

- Areas of pain or sensitivity, Straightness of teeth, Bleeding of gums, Clicking or popping jaw, Bad Breath, etc.

Have you been told you need antibiotics before dental treatment? Y N Reason _____

Is there anything not listed that you think we should know about you? _____

I acknowledge that I have answered the above questions correctly and to the best of my ability. All my questions regarding this form have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of person completing form

Relationship if other than patient