WELCOME

•Patient Name: _____

•DOB: _____ • Phone #: _____

Conditions	Does the patient have any MEDICAL CONDITIONS? (For example: ADHD, Asthma, Autism, Cerebral Palsy, Diabetes, Epilepsy, Seasonal Allergies, ETC)	__YES	__NO
	If YES, what conditions?		
	Does the patient have any HEART conditions? (For example: Heart Murmur, congenital Heart Defects, ETC)	__YES	__NO
	If YES, what conditions?		
	Does the patient require an ANTIBIOTIC before being seen?	__YES	__NO
	If YES, did the patient take the antibiotic?	__YES	__NO
	Does the patient have any history of Cancer or Kidney Disease?	__YES	__NO
	If Yes, please explain:		
	Is there any possibility of pregnancy?	__YES	__NO
Allergies	Does the patient have an ALLERGY to LATEX?	__YES	__NO
	Does the patient have any OTHER ALLERGIES? (For example: Animals, Foods, Medications, Nickel, ETC)	__YES	__NO
	If YES, what allergies?		
Medications	Is the patient currently taking ANY Medications/Vitamins?	__YES	__NO
	If Yes, what medications/Vitamins? Why is the patient taking this medication (what condition is it for)?		
Dental Concerns	Do you (or the patient) have any DENTAL CONCERNS?	__YES	__NO
	If YES, what concerns do you have?		
Surgery	Has the patient had any surgeries/hospitalizations in the past 2 years?	__YES	__NO
	If YES, what was the approximate date and reason?		

UPDATE ADDRESS: _____

LEGAL GUARDIAN: _____

It is important that the medical and dental information provided is current and accurate. In order for our doctors to provide safe and effective dental care, it is necessary for them to know you dental history. Thank you for taking you time to fill out this form completely.

DENTAL HISTORY

Name of Previous Dentist_____ Phone #_____

How long has it been since you've seen a dentist? _____

Reason for your dental visit today_____

_____

Have you had any periodontal (Gum) problems?	YES	NO
Do your gums bleed or feel irritated or tender?	YES	NO
Do you floss regularly?	YES	NO
Do you have headaches, earaches or neck pain?	YES	NO
Have you worn braces on your teeth?	YES	NO
Are you happy with the appearance of your teeth?	YES	NO

If not, please explain_____

Are your teeth sensitive to (please circle)	HOT	SWEETS
	COLD	PRESSURE

I certify that the information I have given is correct to the best of my knowledge. If any changes do occur I will notify Route 66 Children's Dentistry and Orthodontics and update my file.

Signature:_____ **Date:**_____