Big Country Dental Care

Patient:	*Medical Concerns:*
Address:	*Birthdate:* *Age:* *Male* ☐ *Female* ☐
City:	*Home #* *Cell #*
Postal Code:	*Work #*
Email:	*AHC #*
Emerg Contact:	*Employer:*
Emerg ph. #	*Occupation :*
Family Doctor:	*DENTAL INSURANCE:*
Dr's Ph #	*CERTIFICATE Number:*
Previous Dentist:	*GROUP Number:*

MEDICAL HISTORY *To be completed by* ***ALL*** *patients*

1. *Are you having dental pain at this time?* ☐ *YES* ☐ *NO*
2. *Do you feel nervous having dental treatment?* ☐ *YES* ☐ *NO*
3. *Have you had a bad experience in a dental office?* ☐ *YES* ☐ *NO*
4. *Have you been a patient in a Hospital in the last two years?* ☐ *YES* ☐ *NO*
5. *Have you been under the care of a physician in the last two years?* ☐ *YES* ☐ *NO*
6. *Have you taken any medication or drugs in the past two years?* ☐ *YES* ☐ *NO*

   Please list any medications: _____
7. *Are you allergic to penicillin, aspirin, codeine, sulfa or any drugs or medications?* ☐ *YES* ☐ *NO*
8. *Have you had any excessive bleeding, especially with dental extractions?* ☐ *YES* ☐ *NO*
9. *Please check any one of the following which you have had or have at present:*

Heart Failure	*Pacemaker*	*Scarlet Fever*	*Glaucoma*	*Congenital Heart Disease*	*Chemotherapy*	*Cough*	*Artificial Joint*	*Rheumatism*	*Hay Fever*	*HIV*
Heart Surgery	*Heart Murmur*	*Rheumatic Fever*	*Venereal Disease*	*Artificial Heart Valve*	*Cancer*	*Headache*	*Anemia*	*Emphysema*	*Sinus Trouble*	*AIDS*
Heart Disease	*Leukemia*	*Tuberculosis*	*Genital Herpes*	*Pain in Jaw Joints*	*Radiation Therapy*		*Stroke*	*Nervous*	*Allergies*	*Hepatitis B (Serus)*
Heart Attack	*Liver Disease*	*Thyroid Diseas*	*Drug Addiction*	*Blood Transfusion*	*Psychiatric Treatment*		*Hives*	*Asthma*	*Fainting/Dizzy*	*Hepatitis A (Infectious)*
Angina Pectoris	*Kidney Failure*	*Diabetes*	*Rheumatism*	*Sickle Cell Trait/Disease*	*Epilepsy/Seizure*		*Ulcers*	*Arthritis*	*Hemophilia*	*Yellow Jaundice*

10. *Do you have any disease or condition not listed?* _____
11. *Do you suffer from shortness of breath or pain in your chest when walking or climbing stairs?* ☐ *YES* ☐ *NO*
12. *Do your ankles swell during the day?* ☐ *YES* ☐ *NO*
13. *Has your weight changed by more than 10 lbs in the last year?* ☐ *YES* ☐ *NO*
14. *Are you on a special diet?* _____ *Doctor's orders or self imposed?* _____
15. ***Women:*** *Are you pregnant now?* Are you practicing birth control? Do you anticipate becoming pregnant?

DENTAL HISTORY

1. *Are you satisfied with the appearance of your teeth and smile?* ☐ *YES* ☐ *NO*
2. *Do you have gum problems?* ☐ *YES* ☐ *NO*
3. *Do you notice popping, clicking, sore j* ☐ *YES* ☐ *NO*
4. *Do you brush and floss daily?* ☐ *YES* ☐ *NO*
6. *Do you grind or clench your teeth?* ☐ *YES* ☐ *NO*
7. *Have you had a difficult extraction?* ☐ *YES* ☐ *NO*
8. *If you get cold sores how frequently do they occur?* _____
9. *When was your last dental visit?* *What was done:*
10. *Do you have difficulty with dental freezing?* ☐ *YES* ☐ *NO*
11. *When were your last dental x-rays taken:*

CHILD'S HISTORY *is there a family history of:*

High decay rate *Tooth Deformity* *Spaced/missing teeth* *Crooked teeth* *Cleft lip/palate* *Gum disease*

Does your child have any oral habits such as: *Thumb/finger sucking* *Grind teeth* *Mouth breathing* *Chewing (pencils, etc)* *Nail/ lip biting*

Has your child received any oral hygiene or tooth brushing instruction from a dentist or hygienist? ☐ *YES* ☐ *NO*

Has your child ever received fluoride supplements? ☐ *YES* ☐ *NO*

CONSENT FOR TREATMENT

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health or if my medicines change, I will inform the dentist at the next appointment without fail. I further consent to the performing of dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetic or any drugs as indicated and I will assume responsibility for the fees associated with those procedures.

DATE: _____ ***SIGNATURE OF PATIENT OR GUARDIAN:*** _____