GOOD NEWS DENTAL

Patient Name _____ **Date of Birth:** ____/____/_____
Address _____
Phone (____)_____
Email_____ **Race:** _____ **Gender:** ___

DENTAL HISTORY

Dentist _____ City _____ Phone (____)_____
Reason for your visit today: _____
Antibiotic Pre-med needed for dental treatment in past? **Yes** **No** **Unknown**
Date of last dental care _____Check (✓) if you have problems with any of the following:

- ☐ Bad breath or taste
- ☐ Bleeding gums
- ☐ Sores or growths in your mouth
- ☐ Food collection between teeth
- ☐ Jaw Pain
- ☐ Your partial or dentures
- ☐ Loose teeth or broken fillings
- ☐ Dry Mouth
- ☐ Sensitivity to cold
- ☐ Persistent swollen neck glands
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting

Other_____

MEDICAL HISTORY

Physician _____ City _____ Phone (____)_____

Please describe medical condition or current or long-term disability if any:

_____

Check (✓) if you have or had any of the following: ☐ Blind ☐ Deaf ☐ Disabled

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease/Disorder
- ☐ Cancer/Chemotherapy
- ☐ Chemical Dependency
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes Type I or II
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Gastrointestinal Disease
- ☐ Glaucoma
- ☐ Headaches/Migraines
- ☐ Heart Attack
- ☐ Heart Problems
- ☐ Hepatitis _____
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Infective Endocarditis
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Neurological Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swollen Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ STD

☐ Parkinson's ☐ Cerebral Palsy ☐ Multiple Sclerosis ☐ Dementia ☐ Intellectual Disability

MEDICATIONS

List current medications, or provide separate list:

_____
_____
_____
_____

Pharmacy Name: _____
Phone : (____) _____

ALLERGIES

- ☐ Aspirin
- ☐ Penicillin
- ☐ Iodine
- ☐ Sulfa
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Others_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold any member of the staff responsible for any errors or omissions that I have made in the completion of this form.

Patient/Personal Rep Signature: _____ **Date** ____/____/_____

Patient/Personal Rep Printed Name: _____