Lowry Y Wong, DDS

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Date

Patient's Name Last First Middle

Date of Birth Social Security Number

1. Dental History

Reason for today's visit:

Former Dentist's Name and Phone Number

Date of last dental visit

Tell us about your current dental problems

Any problems associated with previous dental treatment? If yes, please explain

Does dental treatment make you nervous? Y ☐ N ☐ Are your teeth sensitive to cold, hot or sweets? Y ☐ N ☐

Do your gums bleed when you brush/floss? Y ☐ N ☐ I would like my teeth whiter Y ☐ N ☐

I would like my teeth straighter Y ☐ N ☐ I have chips on my teeth I want fixed Y ☐ N ☐

2. Medical History

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of Physician: Phone Number of Physician:

Please list all prescription and non-prescription medication within the last 6 months:

1. 5.
2. 6.
3. 7.
4. 8.

Do you have or ever had any of the following?

AIDS/HIV POSITIVE	Y	N	HEPATITIS A,B, OR C	Y	N
ARTIFICAL JOINT REPLACE	Y	N	HYPERTENSION	Y	N
ARTHRITIS	Y	N	KIDNEY DISEASE	Y	N
ARTIFICIAL HEART/VALVE	Y	N	LIVER DISEASE	Y	N
ASTHMA	Y	N	LUPUS	Y	N
AUTISM	Y	N	MENTAL HEALTH CONCERNS	Y	N
AUTOIMMUNE DISEASE	Y	N	MITRAL VALVE PROLAPSE	Y	N
BLOOD/CLOTTING DISORDER	Y	N	MOOD OR STRESS DISORDER	Y	N
BRUISE EASILY	Y	N	MULTIPLE SCLEROSIS	Y	N
CANCER	Y	N	ORGAN TRANSPLANT	Y	N
DELAYED HEALING	Y	N	PACEMAKER	Y	N
DIABETES	Y	N	ROUTINE ANTIBIOTICS BEFORE DENTAL VISIT	Y	N
EATING DISORDER	Y	N	RHEUMATIC FEVER	Y	N
DRUG/ALCOHOL DEPENDENCY	Y	N	STROKE	Y	N
EPILEPSY/SEIZURES	Y	N	THYROID DISEASE	Y	N
GLAUCOMA	Y	N	TAKEN IV or ORAL BisPhosphonates	Y	N
FAINTING	Y	N	TUBERCULOSIS	Y	N
HEART DISEASE/ATTACK	Y	N	ULCERS/ ULCERATIVE COLITIS	Y	N
HEART DEFECT/MURMUR	Y	N	RECENT ER VISIT / HOSPITALIZATION	Y	N
HEART PROBLEMS	Y	N	SMOKE	Y	N

Do you have any medical condition not listed above, if so, please explain: _____

_____

Have you been allergic to or had a bad reaction to:

Amoxicillin/Penicillin	Y	N	Codeine	Y	N
Aspirin/Advil/Ibuprofen	Y	N	Dental anesthetic	Y	N
Cephalosporin	Y	N	Erythromycin	Y	N
Clindamycin	Y	N	Latex	Y	N

Any other allergies to medications? _____

WOMEN: Are you pregnant? Y N Month _____

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health and I will not hold my Dentist or any members of his Dental team responsible for errors or emissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status in the future.

Patient or Responsible Party Signature _____ Date _____

Doctor's Signature and Date _____

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