DANE DENTAL LLC

Patient's Name: _____ Birthday:_____

Allergies (please mark (X) for your response to the following questions.)

Local Anesthetics	Yes No	Penicillin or other antibiotics	Yes No
Aspirin	Yes No	Sulfa Drugs	Yes No
Codeine or other narcotics	Yes No	Metals	Yes No
Latex (rubber)	Yes No	Other Allergies	Yes No

Dental History (please mark (X) for your response to the following questions.)

Do your gums bleed:	Yes No	Is your mouth dry?	Yes No
Do you grind your teeth or wear an occlusal guard?	Yes No	Have you had any periodontal treatment?	Yes No
Are your teeth sensitive?	Yes No	Have you had orthodontic treatment?	Yes No
Do you have click, popping, TMJ or jaw discomfort?	Yes No	Have you had any serious injury to your head or mouth?	Yes No
Have you had your wisdom teeth removed?	Yes No		

Previous Dental Provider's Name: _____ Phone Number: _____

When was your last dental cleaning: _____ Were x-ray taken? _____

How many times do you brush a day? _____ How many times do you floss a week? _____

Are you happy with your smile? _____ If no, please explain _____

Do you have concerns about having dental treatment done? _____ If yes, please explain _____

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Patient's Name: _____ Birthday:_____

Medical History (please mark (X) for your response to the following questions.)

Abnormal Bleeding	Yes No	Angina	Yes No
AIDS/HIV	Yes No	Asthma	Yes No
Arthritis	Yes No	Cancer/Chemotherapy/Radiation	Yes No
Cardiovascular Disease	Yes No	Diabetes Type I or II	Yes No
Damaged Heart Valves	Yes No	Eating Disorder	Yes No
Epilepsy	Yes No	Fainting Spells/Seizures	Yes No
G.E. Reflux/heartburn	Yes No	Heart Murmur	Yes No
Hemophilia	Yes No	Hepatitis, Jaundice or Liver Disease	Yes No
High Blood Pressure	Yes No	Low Blood Pressure	Yes No
Mitral Valve Prolapse	Yes No	Pacemaker	Yes No
Persistent Swollen Glands in Neck	Yes No	Sexually Transmitted Disease	Yes No
Sleep Disorder	Yes No	Stroke	Yes No
Do you Snore?	Yes No	Use Tobacco?	Yes No
Have you had a **JOINT REPLACEMENT?**	Yes No		
If yes, do you require a PRE-MED?	Yes No		
Are you currently taking medications?	Yes No	If yes, please list _____	
Are you taking blood thinners?	Yes No	If yes, please list _____	
Women: Are you pregnant?	Yes No	If yes, Due Date _____	

PLEASE LIST OTHER MEDICAL CONDITIONS NOT LISTED ABOVE: _____

Name of Primary Physician: _____ Clinic location of primary physician: _____

I confirm the above information I have provided is correct and to the best of my knowledge. I understand it is my responsibility to inform Dane Dental of any changes in my personal information, insurance changes and medical status.

Print Patient's Name: _____ Date: _____

Patient/Guardian's Signature: _____