WELCOME TO Artisan Dentistry

Patient's First & Last Name (Please Print): ____

DOB: _____-______-________ Physician's Name & Phone: ____

Are you allergic to any of the following? Please select Yes or No.

Aspirin	Codeine	Erythromycin	Penicillin
Anesthetics	Tetracycline	Jewelry/ Metal	Latex

Other

If yes, please list any other allergies: ____________________________________

Please list any prescribed, over-the-counter, vitamins, or supplemental drugs: __________________________

Do you take antibiotics or pre-medication before your dental appointments?

Have you ever taken Fosamax or any other Bisphosphonate?

Do you smoke or use tobacco?

Have you been told you snore or hold your breath while sleeping?

Do you wake up gasping for breath, have sleep apnea, or use a C-Pap machine?

Do you clench or grind your teeth, or wake up with a headache?

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?

Have you ever had any of the following diseases or medical conditions? Please select Yes or No.

Anemia
Arthritis
Artificial Bones/Joints/ Valves
Asthma
Autoimmune Diseases
Blood Transfusion
Cancer/Chemotherapy
Congenital Heart Defect
Diabetes Type: ______
Difficulty Breathing
Drug/Alcohol Abuse
Emphysema/Glaucoma
Epilepsy/Seizure/Fainting
Fever Blisters/Herpes
Heart Attack/Stroke
Heart Murmur
Heart Surgery/Pacemaker
Hemophilia/Bleeding
Hepatitis Type: ______
High Blood Pressure
HIV/AIDS
Kidney Problems
Low Blood Pressure
Mitral Valve Prolapse
Psychiatric Treatment
Radiation Treatment
Rheumatic/Scarlet Fever
Severe/Frequent Headaches
Shingles
Sickle Cell Disease/Traits
Sinus Problems
Tuberculosis
Ulcers/Colitis
Venereal Disease

Please list any other diseases or medical conditions you may have or have had: ___________________________________

Females Only:

Are you using birth control medication? Pregnant? Nursing?

New Patients Only:

What brings you to our office today? ____

Are you currently in pain? If so, where in your mouth is the pain located? ____________________________

Do you like your smile? Do your gums bleed? Have you ever had periodontal disease?

Have you ever had problems with any previous dental treatment?

How many times per day do you brush? _______ Floss? _______ Do you use a manual or electric toothbrush? _________

My signature below indicates that the information that I have given above is correct to the best of my knowledge. I also understand that it is my responsibility to inform the office of any changes in my medical status.

Patient / Guardian Signature: ____ **Date**: _______-______-__________

Doctor Signature: ____ Date: _______-______-__________