Matrix Dental Group

Patient Name: _____ Birth Date: _____ Date Created: _____

Are you under a physician's care now?	❍ Yes ❍No	If yes
Are you taking any medications, pills or drugs?	❍ Yes ❍No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	❍ Yes ❍No	If yes
Do you use tobacco?	❍ Yes ❍No	

Women: Are you...

❑ Pregnanat/Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑ Aspirin	❑ Penicillin	❑ Codeine	❑ Acrylic
❑ Metal	❑ Latex	❑ Sulfa Drugs	❑ Local Anesthetics
❑ Other			

Do you have, or have you had, any of the following?

AIDS/HIV Positive ❍ Yes ❍ No	Diabetes ❍ Yes ❍ No	Hepatitis A	Hepatitis B or C ❍ Yes ❍ No
Rheumatic Fever ❍ Yes ❍ No	High Blood Pressure ❍ Yes ❍ No	Artificial Heart Valve	Excessive Bleeding ❍ Yes ❍ No
Artificial Joint ❍ Yes ❍ No	Irregular Heartbeat ❍ Yes ❍ No	Blood Disease	Kidney Problems ❍ Yes ❍ No
Liver Disease ❍ Yes ❍ No	Stroke ❍ Yes ❍ No	Cancer	Chemotherapy ❍ Yes ❍ No
Mitral Valve Prolap ❍ Yes ❍ No	Heart Attack/Failun ❍ Yes ❍ No	Heart Murmur	Pain in Jaw Joints ❍ Yes ❍ No
Tumors or Growths ❍ Yes ❍ No	Heart Pacemaker ❍ Yes ❍ No	Heart Trouble/Disease	

Have you ever had any serious illness not listed? ❍ Yes ❍No If yes

Dental Information

Reason for today's visit and date of last dental exam?

Dental History

Do you have, or have you had, any of the following?

Bad Breath	❍ Yes ❍ No	Bleeding gums	❍ Yes ❍ No
Dry Mouth	❍ Yes ❍ No	Grinding teeth	❍ Yes ❍ No
Jaw pain or tiredness	❍ Yes ❍ No	Loose teeth	❍ Yes ❍ No
Broken Fillings	❍ Yes ❍ No	Periodontal treatment	❍ Yes ❍ No
Sores or growths in mouth	❍ Yes ❍ No		

Signature

To the best of my knowledge, the questions on this form have been accurately answered. I undewrstand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

X

Date: _____