Matrix Dental Group

Patient Name: _____ Birth Date: _____ Date : _____

Physicians Name: _____

Are you taking any medications, pills or drugs? *(Please list):* _____

_____

_____

Women: Are you...

❑ Pregnant/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? ***(Select Yes or No)***

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

Have you ever had any serious illness or surgeries not listed above? ❍ Yes ❍No If yes _____

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	PeriodontalTreatment	❍ Yes ❍ No
Sores or Growths in Mouth	❍ Yes ❍ No	Tobacco Use	❍ Yes ❍ No

Addresses

Mailing Address: _____

Email Address: _____

Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand 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

Signature of Patient, Parent or Guardian:.

X Date: _____