141 Communications Dr.
Hannibal, MO 63401
Phone (573) 603-1460
Fax (573) 603-1462

639 York St. Suite 212
Quincy, IL 62301
Phone (217) 222-6277
Fax (217) 214-5450

Patient Name: _____ Date of Birth _____

- If adult, does patient have a medical guardian? ☐ Yes ☐ No
  If yes, guardian's name _____
- Primary care physician _____ ☐ current ☐ former
  Last physical exam date: _____
- Are you currently receiving regular physician's care for any condition? ☐ Yes ☐ No
  If yes, for what reasons? If doctor is different than primary, please name. _____
  _____
- Pharmacy of choice: _____ City, State: _____
- (Women) Is there a chance you are pregnant? ☐ Yes ☐ No
  If yes, anticipated due date. _____
- Are you presently taking any medications? ☐ Yes ☐ No
  If yes, please complete the below table

Medication	How Much	How Often	Reason for taking

- Are you allergic/sensitive to: ☐ None ☐ Penicillin ☐ Latex ☐ Sulfa drugs
  ☐ Other (please list) _____
- Do you have diabetes? ☐ Yes ☐ No
  If yes, indicate: ☐ Type 1 ☐ Type 2 Last HbA1c – date and level _____
- Are you receiving Cortico-Steroid treatment? ☐ Yes ☐ No
  If yes, please explain _____
- Are you currently, or have you ever taken oral or IV bisphosphonates? ☐ Yes ☐ No
- Do you smoke, chew, or use E-cigarettes? ☐ Yes ☐ No
  If yes, please indicate which one(s), daily amount, and when you started _____
  _____
- Have you ever used illegal drugs? ☐ Yes (☐ Current or ☐ Former) ☐ No
  If yes, please specify _____

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Medical History

Please mark to indicate any of the following conditions or treatments you currently or have previously had. ***If any yes answers, please provide detail in additional information section below.***

Cardiovascular disorders or conditions

- Congestive heart failure ☐ Yes ☐ No
- Angina (chest pain) ☐ Yes ☐ No
  - If yes, please explain _____
- Pacemaker or implanted defibrillator ☐ Yes ☐ No
- Rheumatic fever ☐ Yes ☐ No
- Congenital heart defect ☐ Yes ☐ No
- Heart attack ☐ Yes ☐ No
  - If yes, when? _____
- Bypass ☐ Yes ☐ No
  - If yes, when? _____
- Artificial heart valve/stent/graft ☐ Yes ☐ No
  - If yes, when? _____

Nervous system or psychological conditions ☐ Yes ☐ No

- If yes, please specify _____

Bleeding or blood problems

- Currently taking a blood thinner or daily aspirin? ☐ Yes ☐ No
  - If yes, please specify _____

Hypertension (High Blood Pressure) ☐ Yes ☐ No

Muscle, bone, or joint conditions

- Osteoporosis ☐ Yes ☐ No
- Joint replacements ☐ Yes ☐ No
  - If yes, which joint(s) and when? _____

Liver disease

- Hepatitis ☐ Yes ☐ No
  - If yes, please indicate type: ☐ A; ☐ B; ☐ C

Kidney or urinary conditions

- Are you currently on dialysis? ☐ Yes ☐ No
  - If yes, how often? _____
- Other kidney or urinary conditions, please list _____

Neurological conditions

- Epilepsy or Seizures ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
  - If yes, when? _____

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Cancer ☐ Yes ☐ No

- If yes, please indicate Type/Site _____
- Have you received chemotherapy or radiation treatment? ☐ Yes ☐ No
  - If yes, please indicate: ☐ Current ☐ Former

Sexually transmitted infections

- Herpes ☐ Yes ☐ No
  - If yes, please indicate: ☐ Oral ☐ Genital
- HIV/AIDS ☐ Yes ☐ No
- Other, please list _____

Physical or Developmental Disability ☐ Yes ☐ No

- If yes, please specify _____
- If yes, are you able to sit and be reclined in a dental chair? ☐ Yes ☐ No

Lung or breathing conditions

- Emphysema/COPD ☐ Yes ☐ No
- Tuberculosis ☐ Yes ☐ No
- Asthma ☐ Yes ☐ No

Gastrointestinal conditions

- Heartburn/acid reflux ☐ Yes ☐ No
- Other, please list _____

Autoimmune disease ☐ Yes ☐ No

- If yes, please list _____

Thyroid disease ☐ Yes ☐ No

• Please list any surgeries or hospitalizations including the date of treatment.

• Additional medical information or details. Please include anything applicable that was not listed above.

☐

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Dental history

- Previous dentist: _____ Office phone number: _____
- When was your: Last dental visit? _____ Last cleaning? _____
- Were X-rays taken at your last dental visit? ☐ Yes ☐ No
- Has any dental treatment been recommended to you that you have not had done? ☐ Yes ☐ No
  If yes, please list _____
- Are you aware of any dental problems? ☐ Yes ☐ No
  If yes, please explain _____
- Have you ever been treated for gum or periodontal disease? ☐ Yes ☐ No
  If yes, what was done? _____ And when? _____
- Have you ever taken or been prescribed premedication before dental treatment? ☐ Yes ☐ No
  If yes, please explain _____
- Do you use fluoridated toothpaste? ☐ Yes ☐ No
- How often do you: Brush _____ Floss _____
- Are your teeth sensitive to: ☐ Cold ☐ Hot ☐ Pressure ☐ Sweets ☐ None
- Please mark to indicate any of the following conditions that apply:
  - Dry mouth/excessive thirst ☐ Yes ☐ No
  - Sore/bleeding gums ☐ Yes ☐ No
  - Loose teeth ☐ Yes ☐ No
  - Difficulty chewing ☐ Yes ☐ No
  - Clenching or grinding habits ☐ Yes ☐ No
  - Popping, clicking, or snapping jaw ☐ Yes ☐ No

I understand that all medications have the potential for accompanying risks, side effects, and drug interactions; therefore, it is critical that I tell my dentist of all medications and/or supplements I am currently taking. To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in health or medications, I will inform the doctor on my next appointment.

_____	_____	_____
Date	Patient or Patient's Guardian Signature	Relationship to Patient
_____	_____	_____
Date	Witness Signature	Interpreter Signature
_____	_____	
Date	Dentist Signature	