Health History provided to Mann Family Dental, LLC

Patient Name:_________________________________ DOB:____/____/____ DATE:______________

Dental History **Do you have a specific dental problem: Yes No**
____

Have you had routine dental care in the past: Yes No ______________________________________

Do you like your smile? Yes No ____

Do you have any of the following? (Please check all that apply to you)

☐ **Broken Fillings** ☐ **Swelling in mouth** ☐ **Injury to teeth or jaw** ☐ **Bleeding gums** ☐ **Decayed Teeth**

Medical History **BP:____/_____ Pulse:________**

Are you under the care of a physician, past or present? Yes No ______________________________

Have you ever had a serious injury to the head or neck? Yes No ______________________________

Have you had any artificial joint replacements? Yes No if yes when?___________________________

Do you have any allergies to the following medications or materials? Yes No ___________________

☐ **Penicillin** ☐ **Codeine** ☐**Metal** ☐**Latex**
☐**Other_____________________________**

Tobacco Use? Yes No If yes what type: ____

Current Medication:____

Women (Please Check) ☐ **Pregnant (# Weeks)______** ☐ **Not Pregnant** ☐ **Nursing** ☐ **Taking Contraceptives**

Do you now or have you ever had the following?

Cancer	Yes No	Kidney Problems	Yes No	Osteoporosis	Yes No
Breathing Difficulty	Yes No	Renal Dialysis	Yes No	IV Bisphosphonates	Yes No
Tuberculosis	Yes No	Mental Disabilities	Yes No	Endocarditis	Yes No
Thyroid Disease	Yes No	Drug Addiction	Yes No	Bleeding Issues	Yes No
Asthma	Yes No	Stroke	Yes No	High Blood Pressure	Yes No
Diabetes	Yes No	Cold Sores	Yes No	Low Blood Pressure	Yes No
Artificial Joint	Yes No	Psychiatric Care	Yes No	Seizures/Epilepsy	Yes No
Hepatitis	Yes No	Hives or Rash	Yes No	Heart Condition	Yes No
AIDS/HIV Positive	Yes No	Pacemaker	Yes No	Liver Condition	Yes No

Have you ever had any other serious illness not checked above? Yes No _____________________________

Do you wish to discuss anything privately with the dentist? Yes No ________________________________

X____ Date:__________________
Patient Signature (Parent or Guardian) To the best of my knowledge the above information is correct
Reviewed by Doctor or RDH ____ Date: ________________