



Jorge Oaxaca DDS, Inc. and Howard Ong DDS, FAGD, Inc.

Restorative, Cosmetic and Implant Dentistry

Dental Info:

Reason for today's visit: Exam Emergency Consultation

Are you in pain? Yes No How long? _____

Please indicate any of the following problems:

Discomfort, clicking or popping in jaw. Lost/Broken fillings(s) Stained teeth

Red, swollen or bleeding gums. Teeth grinding Locking jaw

Sensitive tooth, teeth or gums. Ringing in Ears Bad breath

Blister/Sores in or around the mouth. Broken/Chipped tooth Other: _____

Do you require pre-medication? Yes No Don't know

Previous Dentist: Name: _____ Phone#: _____

Last Dental Exam: ____/____/____ Last Dental X-rays: ____/____/____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? Soft Medium Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Medical History:

What medications are you taking? Blood thinners Pain killers (including aspirin) Antibiotics

Bisphosphinates(for osteoporosis) Other(s), please list: (or attach list) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

- | | | | |
|-----------------------------|-----------------------------|--------------------------------|------------------------------|
| Y N Heart Attack/Stroke | Y N Thyroid Problems | Y N Cancer/Tumors | Y N Cosmetic Surgery |
| Y N Heart Surg./Pacemaker | Y N Kidney Problems | Y N Shingles | Y N Xray or Cobalt Treatment |
| Y N Heart Murmur | Y N Liver Problems | Y N Hepatitis | Y N Chemotherapy |
| Y N Rheumatic Fever | Y N Respiratory Problems | Y N HIV+/Aids/ARC | Y N Asthma |
| Y N Mitral Valve Prolapse | Y N Sinus Problems | Y N Arthritis/Rheumatism | Y N Difficulty Breathing |
| Y N Artificial Valves | Y N Stomach Problems/Ulcers | Y N Artificial Bones/Joints | Y N Diabetes/Hypoglycemia |
| Y N Heart Disease | Y N Psychiatric Problems | Y N Emphysema | Y N Leukemia |
| Y N Congenital Heart Defect | Y N High Cholesterol | Y N Fainting/Seizures/Epilepsy | Y N Anemia |
| Y N Chest Pains | Y N Alcohol/Drug abuse | Y N Severe/Frequent Headaches | Y N High/Low Blood Pressure |
| Y N Scarlet Fever | Y N Tuberculosis TB | Y N Frequent Neck Pain | Y N Bleeding Problems |
| Y N Nervousness | Y N Jaw Problems TMJ/TMD | Y N Back Problems | Y N Glaucoma |

Please list any other surgeries or medical conditions you have or ever had: (or attach list)

Are you allergic to any of the following? Latex Pencillin/Amoxicillin Tetracycline Aspirin

Dental Anesthetics Foods: _____ Others: _____

Do you use tobacco? No Yes/How used? _____ How much? _____ How long? _____

For women: Are you taking Birth Control pills? Yes No How many children have you had? _____

Are you pregnant? Yes No/How far along? _____ Are you nursing? Yes No

*I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient-Print: _____ Sign: _____ Date ____/____/____

Doctor Signature _____ Date ____/____/____