Medical History (cont.)

Please List Current Medications: Prescription and Over-the-Counter:

	Name of Medication	Dose	Frequency	Updated
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Dental History

Previous Dentist:_____ Phone:_____

Do you like your smile? Yes ◯ No ◯

Are you apprehensive about dental treatment? Yes ◯ No ◯

If the patient is a child, does he/she take a fluoride supplement or have fluoride in their home water? Yes ◯ No ◯

Do you have any current dental pain or other issues you'd like addressed? Yes ◯ No ◯

Comments:_____

_____

_____

_____

_____

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 my (or patient's) medical status.

_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:_____

DATE:_____ **REVIEWED BY**:_____

Clear Form