COMMUNITY HEALTH CENTERS OF CENTRAL WYOMING
CASPER • DUBOIS • RIVERTON

DENTAL CLINIC – PATIENT MEDICAL & DENTAL INFORMATION

Patient Name _____ Date of Birth _____ Patient ID _____

MEDICAL INFORMATION

	Yes	No
Are you now under the care of a physician? If so, Physician Name_____ Phone:_____	☐	☐
Females: Could you be or are you pregnant?	☐	☐
Do you use controlled substances (drugs)?	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)? If so, how long? _____	☐	☐
Have you used tobacco in the past?	☐	☐
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐
Are you taking or scheduled to begin taking either of the medications Alendronate (Fosamax®) or Risedronate (Actonel®) for Osteoporasis or Paget's Disease?	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's Disease, multiple myeloma or metastatic cancer? Date treatment began:	☐	☐

	Yes	No
Active Tuberculosis?	☐	☐
Persistent Cough greater than a three (3) weeks duration or Cough that produces blood?	☐	☐
Have you had a serious illness, operation or been hospitalized in the past five (5) years?	☐	☐
Are you taking or have you recently taken any prescription or over-the-counter medicine(s)?	☐	☐
Have you ever had an allergic reaction to local anesthetic?	☐	☐

Please *list all medicines* including aspirin, vitamins, natural or herbal preparations and/or diet supplements:

_____
_____
_____
_____

List all DRUG ALLERGIES (Penicillin, latex, codeine)

_____
_____
_____

	Yes	No		Yes	No		Yes	No
Anemia ……..	☐	☐	Hemophilia ……..	☐	☐	Mitral Valve Prolapse …..	☐	☐
Alcohol Use ……...	☐	☐	Asthma …….	☐	☐	Organ Transplant …….....	☐	☐
Aneurysm ……..	☐	☐	Blood Disease ……..	☐	☐	Pancreatitis …….....	☐	☐
Angina/Chest Pain …….	☐	☐	Cancer ……..	☐	☐	Pneumonia …….....	☐	☐
GERD/Chronic Heartburn …….	☐	☐	Coumadin …….	☐	☐	Respiratory Problem ….....	☐	☐
Pacemaker ……..	☐	☐	Diabetes ……	☐	☐	Rheumatic Fever …….....	☐	☐
Artificial Heart Valve ……	☐	☐	STD/Venereal Disease …….	☐	☐	Skin Problem/Rash …….....	☐	☐
Previous infective Endocarditis ……...	☐	☐	Eating Disorder …..…..…..…...	☐	☐	Stomach/Intestinal Prob….	☐	☐
Damaged Valves in transplanted Heart ……..	☐	☐	Emotional Problems …….	☐	☐	Stroke …….....	☐	☐
Congenital Heart Disease ……..	☐	☐	Emphysema …..…..…..…..…...	☐	☐	Surgery …..…..…..….....	☐	☐
Unrepaired Cyanotic CHD ……	☐	☐	Epilepsy/Seizure ……..……	☐	☐	Thyroid Disease …….....	☐	☐
Repaired (completely) in last six (6) months …….	☐	☐	Fibromyalgia ……	☐	☐	Tumor or Growth …….....	☐	☐
Repaired CHD with residual defects ……..	☐	☐	Hepatitis A, B, or C ……..	☐	☐	Glaucoma …….....	☐	☐
			Herpes/Cold Sore …..…..…..…	☐	☐	Sleep Disorder …..….....	☐	☐
			High Blood Pressure ……	☐	☐	Hospitalization …….....	☐	☐
			HIV/AIDS ……	☐	☐	Kidney Problems …….....	☐	☐
			Heart Murmur ……..	☐	☐	Liver Problems …….....	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐

Name of physician or dentist making this recommendation _____ Phone: _____

DENTAL INFORMATION

	Yes	No		Yes	No
Do your gums bleed when you brush/floss?	☐	☐	Do you have earaches or neck pain?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	Are you currently experiencing dental pain or discomfort?	☐	☐
Does food or floss catch between your teeth?	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐
Is your mouth dry?	☐	☐			
Have you had any periodontal (gum) treatments?	☐	☐	Date of your last dental exam: _____		
			What was done at that time: _____		
Have you ever had orthodontic (braces) treatments?	☐	☐	Date of last dental x-rays:_____		

What is the reason for your dental visit today? _____

How do you feel about your smile?

To the best of my knowledge the above information is true and correct. I understand this information will be kept confidential. I will inform the doctor of any changes in my health and medical condition, or if my medicines change.

Patient/Guardian Signature: _____Date:_____ Staff Initials: _____