Douglas Dental Care
Joel R. Tidwell, DDS
Dimitri Arfanakis, DMD
Medical and Dental History

Patient Name: _____ _____ ____ _____
Last First M Preferred Name

Please provide information regarding your medical history to the best of your knowledge. If you require information, ask one of our staff members for assistance.

Are you in good health?	□ Yes	□ No
Has there been any change in your general health in the last year?	□ Yes	□ No
Are you now under the care of a physician for a particular problem?	□ Yes	□ No
Have you ever had any serious illnesses, operations, or hospitalizations?	□ Yes	□ No

Please provide your physician's name, address, and phone number below.

_____ _____
Physician's Name Street

_____ _____
Physician's Phone City, State, Zip

Do you have or have you taken any of the following?

□ *Artificial heart valves	□ *Congenital heart defect	□ *Heart transplant	□ *Endocarditis
□ *Joint replacement	□ Anemia	□ Asthma	□ ^Bisphosphonates
□ Bleeding disorders	□ Blood transfusion	□ Bronchitis	□ Cancer
□ Chemotherapy	□ Contact lenses	□ COPD	□ Diabetes
□ Emphysema	□ Excessive bruising	□ Excessive thirst	□ Heart attack/Stroke
□ Heart palpitations	□ High blood pressure	□ Kidney disease	□ Leukemia
□ Liver disease	□ Mental disorders	□ Nervous disorders	□ Pacemaker
□ Persistent cough	□ Pregnancy	□ Radiation treatment	□ Shunts or conduits
□ Sinus problems	□ Stomach problems	□ Tuberculosis	□ Tumors
□ Ulcers	□ Allergy: Codeine	□ Allergy: Dairy	□ Allergy: Epinephrine
□ Allergy: Latex	□ Allergy: Penicillin	□ Allergy: Seasonal	□ Allergy: Sulfa drug

Please list any conditions or allergies you may have that are not listed above.

Please list any prescription and over-the counter medication you are currently taking.

FOR FEMALE PATIENTS: Please note that if you are using oral contraceptives, it is important to understand that antibiotics (and other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you should use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult your physician for further guidance.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Douglas Dental Care has my permission to ask the respective health care provider/agency for any pertinent information. I will notify Douglas Dental Care dentists and staff of any changes in health or medication. I hereby give consent for dental treatment which may include anesthesia. I will discuss any questions concerning treatment and fees with the dentist.

Signature: _____ **Date:** _____

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Last First M Preferred Name

Please provide information regarding your dental history to the best of your knowledge. If you require information, ask one of our staff members for assistance.

Do you smoke cigarettes, cigars, or pipes?	□ Yes	□ No	Amount: _____/day
Do use use snuff or chew?	□ Yes	□ No	Amount: _____/day
Do you consume alcoholic beverages?	□ Yes	□ No	Amount: _____/day

Using tobacco products (cigarettes, cigars, snuff, etc...) and consuming alcoholic beverages increases oral cancer risk. Early detection through our advanced oral cancer screenings is key to increased survival. Are you interested in our advanced oral cancer screening procedure today? □ Yes □ No

Do you brush your teeth regularly?	□ Yes	□ No
Do you floss your teeth regularly?	□ Yes	□ No
Have you been told that you have periodontal (gum) disease?	□ Yes	□ No
Have you ever had a periodontal (gum) treatment?	□ Yes	□ No
Have you ever had a deep cleaning?	□ Yes	□ No
Do you experience bad breath?	□ Yes	□ No
Do you experience dry mouth?	□ Yes	□ No
Do you grind or clench your teeth?	□ Yes	□ No
Do your jaws make popping or clicking noises?	□ Yes	□ No
Do you have difficulty opening or experience pain in your jaw?	□ Yes	□ No
Are your teeth sensitive or uncomfortable?	□ Yes	□ No
Do you participate in contact sports?	□ Yes	□ No
Do you have a nightguard or mouthguard?	□ Yes	□ No
Do you snore?	□ Yes	□ No
Are you interested in anti-snoring aids to decrease snoring?	□ Yes	□ No
Would you like to improve your smile?	□ Yes	□ No
Would you like to whiten your teeth?	□ Yes	□ No
Would you like to straighten your teeth?	□ Yes	□ No
When was your last dental appointment?	_____	
Have you had your teeth cleaned within the last 12 months?	□ Yes	□ No
Have you had x-rays taken of your teeth in the last 12 months?	□ Yes	□ No

Please provide your previous dentist's name, address, and phone number below.

_____ _____
Dentist's Name Street

_____ _____
Dentist's Phone City, State, Zip

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Signature: _____ **Date:** _____