Chris B. Lundell, DDS, PC
Ellen P. Hoy, DDS
Benjamin C. Lundell, DDS

First Name: __________________________ Middle Initial__________ Last Name: ____

Although dentists primarily treat the area in and around your mouth, we view your mouth as a part of your entire body. Furthermore, health problems that you may have, or medications you may be taking, could have an important effect with the dentistry you will receive. Thank you for answering the following questions.

GENERAL HEALTH (Please Circle)

Are you currently under a physician's care? Yes No If yes, physician's name:_______________________________

Physician's phone #:_______________________________

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:_______________________________

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Have you ever had a serious head or neck injury Yes No If yes, please explain:_______________________________

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Have you ever taken medication containing bisphosphonates? Yes No If yes, please explain:_______________________________
(i.e. Fosamax, Boniva, Actonel)

Are you currently or have you previously used tobacco? Yes No If yes, please explain:_______________________________
(ie. cigarettes, cigars, chewing tobacco)

ALLERGIES (Please Circle)

Do you have any allergies? Yes No

Please list allergies: _______________________________

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WOMEN:

Are you pregnant/trying to get pregnant? Yes No

Are you taking oral contraceptives? Yes No

Are you nursing? Yes No

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING? (Please Circle)

AIDS/HIV Positive	Yes	No	Epilepsy or Seizures	Yes	No	Liver Disease	Yes	No
Anemia	Yes	No	Excessive Bleeding	Yes	No	Low Blood Pressure	Yes	No
Artificial Joint	Yes	No	Fainting Spells/Dizziness	Yes	No	Lung Disease	Yes	No
Asthma	Yes	No	Frequent Headaches	Yes	No	Osteoporosis	Yes	No
Breathing Problems	Yes	No	Glaucoma	Yes	No	Psychiatric Care	Yes	No
Bruise Easily	Yes	No	Heart Attack/Failure	Yes	No	Radiation Treatments	Yes	No
Cancer	Yes	No	Heart Pace Maker	Yes	No	Rheumatoid Arthritis	Yes	No
Chemotherapy	Yes	No	Hemophilia	Yes	No	Shingles	Yes	No
Congenital Heart Disorder	Yes	No	Hepatitis A, B, or C	Yes	No	Stomach/Intestinal Disease	Yes	No
Dementia	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Diabetes	Yes	No	Hypoglycemia	Yes	No	Thyroid Disease	Yes	No
Emphysema	Yes	No	Kidney Problems	Yes	No	Venereal Disease	Yes	No

Have you ever had any serious illness not listed above? Yes No If yes, please explain:_______________________________

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PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING.

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Consent: 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 medical status. Lundell and Hoy Dentistry may disclose such information to my (or patient's) insurance company for the purpose of obtaining payment for services and determining insurance benefits.

_______________________________________ _______________________
Signature of Patient, Parent, or Guardian Date

Continue with Dental History on next page →

Dental History

Previous Dentist____

Date of last dental exam____

Reason for seeking treatment____

Symptoms

Do you currently have any pain or sensitivity?	Yes	No
Does this pain wake you up at night?	Yes	No
Are your teeth frequently sensitive?	Yes	No
Do your gums bleed when you brush your teeth?	Yes	No
Do you grind or clench your teeth?	Yes	No
Have you ever had any injuries to your mouth or jaws?	Yes	No
Do you have any jaw pain?	Yes	No

Previous Treatment

Have you had your wisdom teeth removed?	Yes	No
Have you ever had orthodontic treatment?	Yes	No
Have you ever been treated for gum disease?	Yes	No
Have you ever had trouble with dental care in the past?	Yes	No
Have you been satisfied with your previous dental care?	Yes	No

Current

Are you interested in keeping your teeth?	Yes	No
Are you currently whitening your teeth?	Yes	No
Are you satisfied with the appearance of your teeth?	Yes	No