



Rockton Dental Care

Health Information

Name: _____

Date of Birth: _____

Have you ever had or do you now have any of the following? Please check those that apply:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney or Liver disease |
| _____ | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Reaction to Metal Jewelry |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV +Test (AIDS Virus) | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Drug Reaction/ Allergy |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Pacemaker | _____ |
| <input type="checkbox"/> Mitral Valve Problems | <input type="checkbox"/> Chemo Therapy | <input type="checkbox"/> Bleeding Disorder | |
| <input type="checkbox"/> Implants (valve, hip, etc) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Heart trouble | | Females: Are you Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Rheumatic or Scarlet Fever | | Due Date: _____ | |

Are you in good health? Yes No

Are you currently taking any medication(s) including aspirin / herbal? Yes No if yes, list all medications: _____

Have you been admitted to a hospital or needed emergency cared during the past two years? Yes No
If yes please explain: _____

Are you now under the care of a physician? Yes No if yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? Yes No If yes, Please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform Rockton Dental Care at the next appointment without fail.

X _____ Date: _____
Signature of patient, parent or guardian

Would you like whiter teeth? Yes No

Are any of your teeth overly sensitive? Yes No

Would you like fresher breath? Yes No

Are bothered by frequent cold/canker sores? Yes No

Referral information

Whom may we thank for referring you to our practice? Another patient Dental Office Website Yellow pages

Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Dental History

Name of former Dentist: _____

Reason for changing: _____