



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"/> Rheumatic or Scarlet Fever |
| <input type="checkbox"/> Implants (valve, hip, etc) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Anemia | |

Females: Are you Pregnant Yes No Due date: _____

Would you like whiter teeth? Yes No **Are any of your teeth overly sensitive?** Yes No

Would you like straighter teeth? Yes No **Have you ever considered braces?** Yes No

If you could change one thing about your smile, what would it be? _____

Are you bothered by frequent cold/canker sores? Yes No

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 care 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

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: _____