FRONT

Westport Plaza Dental
ASSOCIATES

Gary P. Morgan, D.D.S • John A. Waldron, Jr., D.D.S.
Dustin K. Mace, D.D.S.

Name_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	❍ Yes	❍ No	If Yes, please explain: _____
Have you ever been hospitalized or had a major operation?	❍ Yes	❍ No	If Yes, please explain: _____
Have you ever had a serious head or neck injury?	❍ Yes	❍ No	If Yes, please explain: _____
Are you taking any medications, pills or drugs?	❍ Yes	❍ No	If Yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	❍ Yes	❍ No	_____
Are you on a special diet?	❍ Yes	❍ No	
Do you use tobacco?	❍ Yes	❍ No	

Women: Are you ❍ Pregnant/Trying to get pregnant? ❍ Nursing? ❍ Taking oral contraceptives?

Are you allergic to any of the following?

❍ Aspirin ❍ Penicillin ❍ Codeine ❍ Acrylic ❍ Metal ❍ Latex ❍ Local Anesthetics ❍ Other

If yes, please explain: _____

Do you have, or have you had, any of the following?

- ❍ AIDS/HIV Positive
- ❍ Anaphylaxis
- ❍ Anemia
- ❍ Angina
- ❍ Arthritis/Gout
- ❍ Artificial Heart Valve
- ❍ Artificial Joint
- ❍ Asthma
- ❍ Blood Disease
- ❍ Breathing Problem
- ❍ Bruise Easily
- ❍ Cancer
- ❍ Chemotherapy
- ❍ Chest Pains
- ❍ Cold Sores/Fever Blisters
- ❍ Congenital Heart Disorder
- ❍ Convulsions
- ❍ Cortisone Medicine
- ❍ Diabetes
- ❍ Drug Addiction
- ❍ Easily Winded
- ❍ Emphysema
- ❍ Epilepsy or Seizures
- ❍ Excessive Bleeding
- ❍ Excessive Thirst
- ❍ Fainting Spells/Dizziness
- ❍ Frequent Cough
- ❍ Frequent Diarrhea
- ❍ Frequent Headaches
- ❍ Genital Herpes
- ❍ Hay Fever
- ❍ Heart Attack/Failure
- ❍ Heart Murmur
- ❍ Heart Pace Maker
- ❍ Heart Trouble/Disease
- ❍ Hemophilia
- ❍ Hepatitis A
- ❍ Hepatitis B or C
- ❍ Herpes
- ❍ High Blood Pressure
- ❍ Hives or Rash
- ❍ Hypoglycemia
- ❍ Irregular Heartbeat
- ❍ Kidney Problems
- ❍ Leukemia
- ❍ Liver Disease
- ❍ Low Blood Pressure
- ❍ Lung Disease
- ❍ Mitral Valve Prolapse
- ❍ Osteoporosis
- ❍ Pain in Jaw Joints
- ❍ Parathyroid Disease
- ❍ Psychiatric Care
- ❍ Radiation Treatments
- ❍ Renal Dialysis
- ❍ Rheumatic Fever
- ❍ Rheumatism
- ❍ Scarlet Fever
- ❍ Shingles
- ❍ Sickle Cell Disease
- ❍ Sinus Trouble
- ❍ Stomach/intestinal Disease
- ❍ Stroke
- ❍ Swelling of Limbs
- ❍ Thyroid Disease
- ❍ Tonsillitus
- ❍ Tuberculosis
- ❍ Tumors or Growths
- ❍ Ulcers
- ❍ Venereal Disease
- ❍ Yellow Jaundice

Have you ever had any serious illness not listed above? ❍ Yes ❍ No

If Yes, please explain: _____

Comments: _____

_____

_____

_____

In the event of an emergency, who should we contact? _____

Relationship _____ Home # _____ Work # _____

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.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

Reviewed by _____ Date _____

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Quality is never an accident. It is always the result of...high intention, sincere effort and skillful execution. It represents...the wise choice of many alternatives.

Dental Health

Are your teeth sensitive to:

YES ____	NO ____	Heat
YES ____	NO ____	Cold
YES ____	NO ____	Sweets
YES ____	NO ____	Biting Pressure
YES ____	NO ____	Does food constantly get stuck between certain teeth?
YES ____	NO ____	Do you get frustrated because you always have something to be treated or repaired when you visit the dentist?
YES ____	NO ____	Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc.
YES ____	NO ____	Do you have fillings that show in your front teeth that you don't like?
YES ____	NO ____	Do your gums bleed when you brush your teeth?
YES ____	NO ____	Do you ever avoid any part of your mouth while brushing?
YES ____	NO ____	Do you have an unpleasant taste or odor in your mouth?
YES ____	NO ____	Has the fear of discomfort kept you from regular dentist visits?
YES ____	NO ____	Are you concerned about the finances required to return your mouth to excellent dental health?

How often do you brush your teeth? _____ How often do you floss? _____

How long since your last thorough exam with full mouth x-rays? _____

If you could change the appearance of your teeth, what would you do? _____

Authorization to Perform Dental Treatment

1. I authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment, mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete listing of any possible complications for a certain procedure.

_____ Signature of patient or responsible party

_____ Today's Date