Belfast Dental Care

Patient Name (please print):_____

Today's Date:_____ Patient's Date of Birth:_____

Welcome to Belfast Dental Care! Your oral health has a potential impact on your overall health. Belfast Dental Care requests this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. No persons outside Belfast Dental Care will be provided this information unless properly authorized by you or required by law. Thank you for answering the following general health questions.

Dental History

Why are you seeking dental care today?_____

When was your last dental exam?_____ Who performed the exam?_____

Please circle/ answer all that apply:

1. I have regular dental exams.
2. I have had trouble with past dental treatment.
3. My gums bleed when I brush/floss.
4. My teeth are sensitive to hot, cold, sweet, pressure.
5. Dental floss catches between my teeth.
6. My mouth is dry.
7. I have had periodontal/gum or orthodontic treatment.
8. My drinking water is fluoridated, bottled or filtered.
9. I experience pain or discomfort in my mouth, neck or ears.
10. My jaw pops, clicks or hurts.
11. I grind my teeth.
12. I have sores or ulcers or lesions in my mouth.
13. I have had a serious injury to my mouth or head.
14. I am completely satisfied with the appearance of my teeth.
15. I wear dentures or partials.
16. In the past, fear has prevented me from seeking dental treatment.
17. I snore/have sleep problems

IMPORTANT

Please circle/list any known allergies:

Penicillin Clindamycin

Other Antibiotics _____

Local Anesthetics Aspirin Codeine

Acrylic Metal Latex

Other known Allergy(ies)_____

Medical History

Do you have Active Tuberculosis, a persistent cough more than 3 weeks, a cough that produces blood or exposure to tuberculosis? If yes to any of these, please stop and return this form to the receptionist.

Do you have (or have you ever had) any of the following? *(Please check all that apply)*

__AIDS/HIV infection	__Alzheimer's	__Anaphylaxis	__Angina (chest pains)
__Arteriosclerosis	__Artificial Heart Valve	__Arthritis (Osteo or rheumatoid)	
__Artificial Joint(s)	__Asthma	__Autoimmune Disease	__Blood Pressure (High or Low)
__Bleeding Problem, Anemia or other blood disease		__Breathing Problems	__Cardiovascular Disease
__Cancer	__Chemotherapy, Radiation	__Cold Sores/Fever Blisters	__Congenital Heart Disease
__Congestive Heart Failure	__Diabetes 1 or 2	__Hypoglycemia	__Jaundice
__Irregular Heartbeat	__Emphysema	__Epilepsy or Seizures	__Excessive Urination

***Continued on other side**

__Fainting/Dizziness	__Frequent Cough	__Frequent Diarrhea	__Frequent Headaches
__Hepatitis A, B, C, D or E	__Herpes	__Hives/Rash	__Kidney Problems
__Leukemia	__Liver Disease	__Lung Disease	__MRSA
__Neurological Disorder	__Osteoporosis	__Pacemaker	__Parathyroid Disease
__Persistent Heartburn	__Rheumatic Heart Disease	__Rheumatic Fever	__Sinus Trouble
__Sleep Problems/Disorder	__Shingles	__Sickle Cell Disease	__Stomach/Intestinal Disease
__Stroke	__Thyroid Disease	__Tuberculosis	

Do you have any disease, condition or problem not listed here? If so, describe:_____

Have you been hospitalized or had a major surgery in the past 6 months? Reason:_____

Do you use tobacco? If so, form used:_____ Frequency:_____

Do you need to pre-medicate?_____ Are you on a special diet?_____ Are you currently under a physician's care?_____

Are you, or have you ever been addicted to a chemical substance?_____ Do you, or have you ever taken, Phen Fen or Redux?_____

Women: Are you pregnant, trying to get pregnant, taking oral contraceptives or nursing? (Please circle any that apply)

Are you taking any pills, medications or drugs? NO YES If yes, please list:

_____ _____ _____ _____

_____ _____ _____ _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that the dentist and staff will rely on this information to treat me. I will not hold the dentist, staff or Belfast Dental Care responsible for any actions they take or don't take due to my errors and omission on this form. It is my responsibility to inform the dental office of any changes in my medical status.

I would like a copy of the Belfast Dental Care Patient Privacy Notice: Yes No

Name of responsible adult completing this form is other than patient:_____

Relationship to patient:_____

_____ _____

PATIENT OR PARENT/GUARDIAN SIGNATURE DATE

BDC Office Use Only