LEEDENTAL CENTERS

Patient Personal Information

Last, First		Account No.	
Birth Date		Email	

Patient Medical Information

Allergic To

- ☐ Amoxicillin
- ☐ Penicillin
- ☐ Tetracycline/Minocycline
- ☐ Clindamycin
- ☐ Aspirin
- ☐ Barbiturates / Sleeping Pills
- ☐ Codeine / Other Narcotics
- ☐ Latex Rubber
- ☐ Local Anesthetics/Epinephrine
- ☐ Metals
- ☐ Sulfa Drugs

Check, if applicable

- ☐ AIDS
- ☐ HIV Infection
- ☐ Acid Reflux
- ☐ Alcohol/Drug Abuse
- ☐ Alzheimers/Dementia
- ☐ Anemia
- ☐ Anorexia / Bulimia
- ☐ Anxiety
- ☐ Arthritis - Osteoarthritis
- ☐ Arthritis - Rheumatoid
- ☐ Asthma / Hay Fever
- ☐ Autoimmune Disease
- ☐ Bipolar
- ☐ Blood Clotting Problems
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer/Tumor or Growth
- ☐ Cardiovascular Disease
- ☐ Angina
- ☐ Damaged Heart Valve
- ☐ Heart Valve Replacement
- ☐ Rheumatic Heart Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Mental Health Problems
- ☐ Chest Pain Upon Exertion
- ☐ COPD
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells / Seizures
- ☐ Fever Blisters / Cold Sores
- ☐ Fibromyalgia
- ☐ Frequent Headaches
- ☐ Frequently Dry Mouth
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Joint Replacement
- ☐ Kidney/Bladder Trouble
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lupus
- ☐ Neurological Disorder
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Premedicate - Dental Treatment
- ☐ Sexually Transmitted Disease
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Sleep Apnea/Sleep Disorder
- ☐ Swollen Glands
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Unusual Weight Loss
- ☐ Urinate Frequently
- ☐ Sjogren's Syndrome

Medical Questionnaire

Medical Questionnaire

Have you had any serious illness, operation or hospitalization within the past 5 years?	☐ Yes	☐ No
If Yes, what illness or problem ?		
Are you currently taking any medication, prescription and/or over the counter ?	☐ Yes	☐ No
If Yes, please list?		
Are you an alcoholic/recovering alcoholic?	☐ Yes	☐ No
Do you use recreational drugs?	☐ Yes	☐ No
Has a physician or dentist ever recommended you take antibiotics prior to your dental treatment?	☐ Yes	☐ No

Women Only

Are you pregnant?	☐ Yes	☐ No
If Yes, what is your due date ?		
Are you currently nursing ?	☐ Yes	☐ No

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list

PLEASE TURN OVER

Dental Questionnaire

Dental Questionnaire

Date of your last cleaning		
Last exam date		
Date of your last x-rays		
Any difficulties with previous dental treatment?	☐ Yes	☐ No
If yes, please list		
Are you currently having any dental problems?	☐ Yes	☐ No
If yes, please list		
Do your gums bleed while brushing or flossing?	☐ Yes	☐ No
Have you ever been told you have periodontal (gum) disease?	☐ Yes	☐ No
Have you had any periodontal treatment (deep cleaning/surgery)?	☐ Yes	☐ No
Are your teeth sensitive to hot, cold or sweets ?	☐ Yes	☐ No
Do you chew/smoke tobacco in any form ?	☐ Yes	☐ No
If yes, what is the quantity and duration of use?		
Have you had any head, neck or jaw injuries?	☐ Yes	☐ No
Do you notice popping, clicking or soreness of the jaws or points just in front of the ears?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Do you snore or have you been diagnosed with sleep apnea?	☐ Yes	☐ No
Have you ever had orthodontic treatment?	☐ Yes	☐ No
Would you like your teeth straightened?	☐ Yes	☐ No
Do you wear dentures or partials?	☐ Yes	☐ No
Would you like your teeth whiter?	☐ Yes	☐ No
If you could change anything about your smile, what would it be?		
Additional Comments from Patient		
Additional Comments from Provider		

NOTE: Both Doctor and patient are encouraged to discuss any or all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not old Lee Dental Centers, Dentist(s), or any other employee(s) or agent(s) of Lee Dental Centers responsible for any action they take or do not take because of errors or omissions that I may have made in the ompletion of this form. I will notify my Dentist and Lee Dental Centers of any change in my health.

Patient/Guardian Signature **Date**

Provider Signature **Date**