

# **WELCOME**

## **MERTZ FAMILY DENTISTRY**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Are you receiving any type of medical treatment at this time?                | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had a recent illness?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you been in the hospital in the past 2 years?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you taking any medication?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you allergic to PENICILLIN or any other medication?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have prolonged bleeding when you are cut requiring medical attention? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been in a drug or alcohol treatment program?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had an injury to your face or jaw?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you smoke?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are you pregnant?   | <input type="checkbox"/> | <input type="checkbox"/> |

List current medications: \_\_\_\_\_

|                            | Yes                      | No                       |                     | Yes                      | No                       |                       | Yes                      | No                       |
|----------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|
| Stroke                     | <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorder      | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy              | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Trouble              | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever     | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes              | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack               | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis        | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS              | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pains                | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease       | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema             | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse      | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis           | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis          | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur               | <input type="checkbox"/> | <input type="checkbox"/> | Tumor / Cancer      | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Dialysis       | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Joints          | <input type="checkbox"/> | <input type="checkbox"/> |                     |                          |                          | Kidney Disease        | <input type="checkbox"/> | <input type="checkbox"/> |
| Glandular Disease          | <input type="checkbox"/> | <input type="checkbox"/> | Asthma              | <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion     | <input type="checkbox"/> | <input type="checkbox"/> |
| STD's                      | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemotherapy/<br>Radiation | <input type="checkbox"/> | <input type="checkbox"/> |                     |                          |                          |                       |                          |                          |

Any other diseases? \_\_\_\_\_

### Dental History

1. Main reason for today's dental visit? \_\_\_\_\_
2. When was your last dental check up? \_\_\_\_\_ Previous dentist's name \_\_\_\_\_
3. Have you ever had an unfavorable reaction or complications from dental treatment? \_\_\_\_\_
4. Do you have sensitive teeth or bleeding gums? \_\_\_\_\_
5. Do you need and antibiotic pre-medication prior to dental treatment? \_\_\_\_\_
6. Do you grind or clench your teeth? \_\_\_\_\_
7. Are you unhappy with the appearance of your teeth? \_\_\_\_\_
8. Have you ever had: gum treatment \_\_\_\_\_ Orthodontic treatment \_\_\_\_\_
9. Do you have questions or concerns regarding your dental treatment? \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_