

New Patient Registration and Health History

Thank you for choosing Greenhaven Family Dental as your dental care provider. Our office is committed to providing you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us - we will be happy to help.

First Name:	Last Name:		Middle Initial:
Today's Date:			
Preferred Name:		Date of Birth:	
Social Security Number:		Male / Female	
Address:		Marital Status:	Single MarriedDivorced
City: Sta	te: Zip:	_	
Employer:		ccupation:	
Who may we thank for referring you	to our office?		
Telephone			
Home Phone:	W	/ork Phone:	
Cell Phone:			
How would you like to receive your re			
Phone E-Mail Text **! Emergency Contact:			
Responsible Party (if someone other th			A At a dalla discissioni.
First Name:		ate of Birth:/	Middle IIIItlai
Address: State:			
Work Phone:			
Insurance Information (If you have pro	vided us with your insuranc	ce card(s), you may skip	this section.)
Primary Insurance	Secondar	y Insurance	
Name of Insurance Co.:	N	ame of Insurance Co.: _	
Plan/I.D. #:			
Policy Holder's Name:	P	olicy Holder's Name:	
Policy Holder's Date of Birth:/	/P	olicy Holder's Date of Bi	rth:/
Policy Holder's SSN:	P	olicy Holder's SSN:	
Policy Holder's Employer:		olicy Holder's Employer:	
			\wedge
	Page 1 of	f 4	OVER

Consent for Use and Disclosure of Health Information

The following release will allow us to share pertinent information regarding your care to enhance your treatment and/or financial reimbursement for services received:

- 1. I authorize Greenhaven Family Dental to share information regarding my course of treatment and the services received with my medical and dental providers in order to enhance my continuing treatment and care.
- 2. I authorize Greenhaven Family Dental and/or any other provider or supplier of services in this office to release any information required to secure payment for services received or the payment of benefits on my behalf. I authorize the use of the signature on all insurance submissions.
- 3. I understand that I am financially responsible for all charges, whether paid or not by insurance, and for all services rendered on my behalf or on behalf of my dependents.
- 4. I acknowledge I have received a copy of this office's Notice of Privacy Practices.
- 5. I authorize Greenhaven Family Dental to use my cell phone number to call regarding appointments, treatment, insurance and my account.

X_			
	Signature of Patient or parent/guardian if minor	Date	

Vho can we share your information with?					
Authorization to Disclose Protected Health Information					
I authorize Greenhaven Family Dental to provide information as requested by the individual(s) below:					
Name:					
If you want to limit the information discussed, specify here:					
Name:					
If you want to limit the information discussed, specify here:					
As stated in Greenhaven Family Dental's Notice of Privacy Practices, this authorization may be revoked at any time except to the extent that Greenhaven Family Dental has taken action in reliance upon this authorization. Revocation must be made in writing to: Greenhaven Family Dental, 13495 Elder Drive, Suite 100, Baxter, MN 56425.					
X					

Health History

Name:	_ [)ate	of Birth:	Today's Date:		
Dental History						
1. Name of your last dentist:			11. Have you ev	er been diagnosed with		
2. Date of your last cleaning:			TMJ/TMD?		Υ	Ν
3. What texture brush do you use?			If so, when?			
SoftMedium Hard			12. Do you snore	e?	Υ	Ν
4. Do your gums bleed while brushing?	Υ	Ν		er had a sleep study?	Υ	Ν
5. Do your gums bleed while flossing?	Υ	Ν		CPAP?	Υ	Ν
6. Are your teeth sensitive to hot, cold, sweet,				d any head/neck/jaw injuries?	Υ	Ν
or sour foods/liquids?	Υ	Ν		frequent headaches?	Υ	Ν
7. Have you noticed any loosening of your				ch or grind your teeth while		
teeth?	Υ	Ν		sleep?	Υ	Ν
8. Does food tend to become caught between			•	do you have a night guard?	Υ	N
your teeth?	Υ	Ν	19. Have you ev			
9. Do you have any sores or lumps in or near				ontic Treatment (braces)?	Υ	Ν
your mouth?	Υ	Ν		gery?	Υ	Ν
10. Have you experienced any of the following?			•	riodontal Treatment?	Υ	Ν
a. Clicking?	Υ	Ν	20. Do you curre	ently have a denture or partial?	Υ	Ν
b. Pain (joint, ear, side of face)?	Υ	Ν	21. Are you sati	sfied with the appearance of		
c. Difficulty in opening or closing?	Υ	Ν	your teeth?)	Υ	Ν
d. Difficulty chewing or swallowing?	Υ	Ν	22. Have you ev	er had an upsetting		
			experien	ce in the dental office?	Υ	N
Made al IPara						
Medical History			12. Da vass vas t	shape (smaling anoff shape)	٧/	
Although dental personnel primarily treat the area				obacco (smoking, snuff, chew)?	Y	N
in and around your mouth, your mouth is a part of			Packs/day?		.,	
your entire body. Health problems that you may				alcoholic beverages?	Υ	N
have, or medication that you may be taking, could			·	drugs or other substances for	.,	
have an important relationship with the dental				al purposes?	Υ	N
care that you will be receiving. Thank you for			•	ng any medication(s) including		
answering the following questions:				upplements, and non-	.,	
1. Are you in good health?	V	N.I	•	n medicine?	Y	N
, -	Y	IN	Please list: _			
2. Have there been any changes in your	V	N.I				
general health in the past year?	Y	IN				
3. Date of your last Physical Exam:						
4. Physician's Name:						
Clinic/Office Name:			16. Pharmacy Na			
Chiney Office Nume.			10. Tharmacy ive	arric.		
Phone Number:						
5. Are you now under a physician's care?	Υ	Ν				
6. Have you ever been hospitalized for any			Women Only:			
surgical operation or serious illness?	Υ	Ν	1. Are you or do	you think you may be		
7. Have you ever taken Fen-Phen/Redux?	Υ	Ν	pregnant?		Υ	Ν
8. Have you had any abnormal bleeding?	Υ	Ν	2. Are you nursii	ng?	Υ	Ν
9. Do you bruise easily?	Υ	Ν	3. Are you taking	g oral contraceptives?	Υ	Ν
10. Have you ever required a blood transfusion?	Υ	Ν	-	•		
11. Do you have a persistent cough or throat						
clearing?	Υ	Ν				
				OVER		>

Medical History Continued

Are you allergic to or have you had reactions to: 1. Local anesthetics like Novocaine?	nedical filstory continued					
2. Penicillin or other antibiotics? Y N Supine]? Y N 3. Sulfa drugs? Y N 28. Sinus trouble? Y N 4. Barbiturates, sleeping pills? Y N 29. Lung or breathing problems? Y N 5. Aspirin? Y N 30. Asthma or hay fever? Y N 7. Latex? Y N 31. Hives or skin rash? Y N 8. Codeine? Y N 33. Leukemia? Y N 9. Foods? 34. Cancer? Y N 33. Leukemia? Y N 10. Other? 35. Radiation therapy/Chemotherapy? Y N 35. Radiation therapy/Chemotherapy? Y N 10. Other? 36. Thyroid problems? Y N 37. Arthritis or rheumatism? Y N 10. Other? 37. Arthritis or rheumatism? Y N 38. Stomach ulcer? Y N 10. Other? 37. Arthritis or rheumatism? Y N 39. Kidney trouble? Y N <td>Are you allergic to or have you had reactions to:</td> <td></td> <td></td> <td>26. Hepatitis, jaundice, or liver disease?</td> <td>Υ</td> <td>N</td>	Are you allergic to or have you had reactions to:			26. Hepatitis, jaundice, or liver disease?	Υ	N
3. Sulfa drugs?	1. Local anesthetics like Novocaine?	Υ	Ν	27. Orthopnea (shortness of breath while		
4. Barbiturates, sedatives, sleeping pills? Y N 29. Lung or breathing problems? Y N 5. Aspirin? Y N 30. Asthma or hay fever? Y N N N 1. Bives or skin rash? Y N	2. Penicillin or other antibiotics?	Υ	Ν	Supine)?	Υ	Ν
5. Aspirin? Y N 30. Asthma or hay Fever? Y N 6. Metals? Y N 31. Hives or skin rash? Y N 7. Latex? Y N 32. Fainting spells or seizures? Y N 8. Codeine? Y N 33. Fainting spells or seizures? Y N 9. Foods? 34. Cancer? Y N N 33. Leukemia? Y N 10. Other? 35. Radiation therapy/Chemotherapy? Y N N 36. Thyroid problems? Y N 10. Other? 36. Thyroid problems? Y N N 38. Stomach ulcer? Y N Anaphalyctic Reaction: Do you carry an epi-pen? Y N 38. Stomach ulcer? Y N N Anaphalyctic Reaction: Do you carry an epi-pen? Y N 39. Kidney trouble? Y N Anaphalyctic Reaction: Do you carry an epi-pen? Y N 39. Kidney trouble? Y N Leterity Y N 39. Kidney trouble? Y N Leterity Y N 42. Sexu	3. Sulfa drugs?	Υ	Ν	28. Sinus trouble?	Υ	Ν
6. Metals? Y N 31. Hives or skin rash? Y N 7. Latex? Y N 32. Fainting spells or seizures? Y N 8. Codeine? Y N 33. Leukemia? Y N 9. Foods? 34. Cancer? Y N 10. Other? 35. Radiation therapy/Chemotherapy? Y N 36. Thyroid problems? Y N 37. Arthritis or rheumatism? Y N 38. Stomach ulcer? Y N Anaphalyctic Reaction: Do you carry an epi-pen? Y N 39. Kidney trouble? Y N 40. Tuberculosis? Y N 40. Tuberculosis? Y N 5. Infective Endocarditis?* Y N 42. Sexually Transmitted Disease (STD)? Y N 4. Artificial joint replacement, screws, pins, plates?* Y N 43. Epilepsy? Y N 4. Artificial joint replacement, screws, pins, plates?* Y N 44. Diabetes? Y N 5. Prosthetic cardiac valve?* Y N 45. Glaucoma? Y N	4. Barbiturates, sedatives, sleeping pills?	Υ	Ν	29. Lung or breathing problems?	Υ	Ν
7. Latex?	5. Aspirin?	Υ	Ν	30. Asthma or hay fever?	Υ	Ν
8. Codeine?	6. Metals?	Υ	Ν	31. Hives or skin rash?	Υ	Ν
9. Foods? 10. Other? 10. Other. 10. Oth	7. Latex?	Υ	Ν	32. Fainting spells or seizures?	Υ	Ν
35. Radiation therapy/Chemotherapy? Y N N 36. Thyroid problems? Y N N 36. Thyroid problems? Y N N 38. Stomach ulcer? Y N N N N N N N N N N N N N N N N N N	8. Codeine?	Υ	Ν	33. Leukemia?	Υ	Ν
10. Other? 36. Thyroid problems? Y N N 37. Arthritis or rheumatism? Y N N 38. Stomach ulcer? Y N N 38. Stomach ulcer? Y N N 38. Stomach ulcer? Y N N 39. Kidney trouble? Y N N 40. Tuberculosis? Y N N 40. Tuberculosis? Y N N 40. Tuberculosis? Y N N 41. AIDS or HIV infection? Y N N 42. Sexually Transmitted Disease (STD)? Y N N 43. Any type of stents?* Y N 44. Anemia? Y N N 44. Anemia? Y N N 45. Epilepsy? Y N N 46. Glaucoma? Y N N 47. Actif deflux/persistent heartburn? Y N N 47. Actif deflux/persistent heartburn? Y N N 48. Psychiatric treatment? Y N N 49. Autism? Y N N N N N N N N N	9. Foods?			34. Cancer?	Υ	Ν
37. Arthritis or rheumatism? Y N 38. Stomach ulcer? Y N N 38. Stomach ulcer? Y N N 39. Kidney trouble? Y N N 40. Tuberculosis? Y N N 40. Tuberculosis? Y N N 40. Tuberculosis? Y N N 41. AIDS or HIV infection? Y N N 42. Sexually Transmitted Disease (STD)? Y N N 43. Epilepsy? Y N N 44. Anemia? Y N N 44. Anemia? Y N N 44. Anemia? Y N N 45. Diabetes? Y N N 46. Glaucoma? Y N N 47. Acid reflux/persistent heartburn? Y N N 47. Acid reflux/persistent heartburn? Y N N 48. Psychiatric treatment? Y N N 49. Autism? Y N N 50. ADD/ADHD? Y N N 51. Fibromyalga? Y N N 51. Fibromyalga? Y N N 51. Fibromyalga? Y N N 52. GERD? Y N N 53. Gout? Y N N 54. Multiple Sclerosis (MS)? Y N N N 75. Hemophilia? Y N N 56. Chronic fatigue? Y N N 56. Chronic fatigue? Y N N 57. Hemophilia? Y N N 75. Fibromyalga? Y N N 75. Fibrom				35. Radiation therapy/Chemotherapy?	Υ	Ν
38. Stomach ulcer?	10. Other?			36. Thyroid problems?	Υ	Ν
Anaphalyctic Reaction: Do you carry an epi-pen?. Anaphalyctic Reaction: Do you carry an epi-pen?. Y N 40. Tuberculosis?. Y N 40. Tuberculosis?. Y N N 40. Tuberculosis?. Y N N 41. AIDS or HIV infection? Y N N 42. Sexually Transmitted Disease (STD)? Y N N 43. Epilepsy? Y N N 44. Anemia? Y N N Antificial joint replacement, screws, pins, plates?* Y N 44. Anemia? Y N N Antificial joint replacement, screws, pins, plates?* Y N 46. Glaucoma? Y N N 50. Prosthetic cardiac valve?* Y N N 47. Acid reflux/persistent heartburn? Y N N 67. Congenital Heart Disease (CHD)?* Y N N 48. Psychiatric treatment? Y N N 48. Psychiatric treatment? Y N N 49. Autism? Y N N N 49. Autism? Y N N 10. Rheumatic heart disease or Rheumatic fever? Y N 50. ADD/ADHD? Y N N 11. Scarlet fever? Y N 53. Gout? Y N N 12. Heart defect, heart murmur or mitral valve prolapse? Y N 55. Eating disorder? Y N N 13. Congestive heart failure? Y N N 57. Hemophilia? Y N N 15. Pacemaker? Y N N 57. Hemophilia? Y N N 15. Pacemaker? Y N N 16. Heart surgery? Y N N N 17. Emphysema? Y N N 18. Eating disorder? Y N N 19. Stroke? Y N N 19. Stroke? Y N				37. Arthritis or rheumatism?	Υ	Ν
Material Programme				38. Stomach ulcer?	Υ	Ν
Do you have or have you ever had the following: 41. AIDS or HIV infection? Y N 1. Infective Endocarditis?* Y N 42. Sexually Transmitted Disease (STD)? Y N 2. Any type of stents?* Y N 43. Epilepsy? Y N 3. Any type of transplant?* Y N 44. Anemia? Y N 4. Artificial joint replacement, screws, pins, plates?* Y N 46. Glaucoma? Y N 5. Prosthetic cardiac valve?* Y N 47. Acid reflux/persistent heartburn? Y N 6. Cardiac valve repair?* Y N 49. Autism? Y N 7. Congenital Heart Disease (CHD)?* Y N 49. Autism? Y N 8. Cardiac transplantation?* Y N 50. ADD/ADHD? Y N 9. Intravascular Access Device?* Y N 51. Fibromyalga? Y N 10. Rheumatic heart disease or Rheumatic fever? Y N 54. Multiple Sclerosis (MS)? Y N 12. Heart defect, heart murmur or mitral valve prolapse? Y N 56. Chronic fatigue? Y N 13. Congestive heart failure? Y N 56. Chronic fatigue? Y N 14. Heart trouble, heart attack, or angina? Y N Y N 15. Pacemaker? Y N 0 Y N 0 Y N 0 16. Heart surgery?	Anaphalyctic Reaction: Do you carry an epi-pen?	Υ	Ν	39. Kidney trouble?	Υ	Ν
1. Infective Endocarditis?* 2. Any type of stents?* 3. Any type of stents?* 4. Any type of stents?* 4. Any type of stents?* 5. Pacemaker? 7. N 4. Attificial joint replacement, screws, pins, plates?* 7. N				40. Tuberculosis?	Υ	Ν
1. Infective Endocarditis?* 2. Any type of stents?* 3. Any type of stents?* 4. Any type of stents?* 4. Any type of stents?* 5. Pacemaker? 7. N 4. Attificial joint replacement, screws, pins, plates?* 7. N	Do you have or have you ever had the following:			41. AIDS or HIV infection?	Υ	Ν
3. Any type of transplant?* Y N 44. Anemia? Y N 44. Artificial joint replacement, screws, pins, plates?* Y N 46. Glaucoma? Y N N 5. Prosthetic cardiac valve?* Y N 47. Acid reflux/persistent heartburn? Y N 6. Cardiac valve repair?* Y N 48. Psychiatric treatment? Y N 7. Congenital Heart Disease (CHD)?* Y N 49. Autism? Y N 8. Cardiac transplantation?* Y N 50. ADD/ADHD? Y N 9. Intravascular Access Device?* Y N 51. Fibromyalga? Y N N 10. Rheumatic heart disease or Rheumatic fever? Y N 53. Gout? Y N 11. Scarlet fever? Y N 53. Gout? Y N 12. Heart defect, heart murmur or mitral valve prolapse? Y N 56. Chronic fatigue? Y N 13. Congestive heart failure? Y N 57. Hemophilia? Y N 14. Heart trouble, heart attack, or angina? Y N N 15. Pacemaker? Y N Do you have any disease, condition, or problem 16. Heart surgery? Y N N 17. Emphysema? Y N N 18. High Cholesterol? Y N N 19. Stroke? Y N 19. Stroke Attack, or angina? Y N 19. Stroke? Y N 19. Stroke Attack antibiotics prior to Y N 19. Stroke Attack antibiotics prior to Y N 19. Stroke Attack antibiotic and dose		Υ	Ν	42. Sexually Transmitted Disease (STD)?	Υ	Ν
44. Artificial joint replacement, screws, pins, plates?*	2. Any type of stents?*	Υ	Ν	43. Epilepsy?	Υ	Ν
plates?*	3. Any type of transplant?*	Υ	Ν	44. Anemia?	Υ	Ν
5. Prosthetic cardiac valve?*	4. Artificial joint replacement, screws, pins,			44. Diabetes?	Υ	Ν
6. Cardiac valve repair?*	plates?*	Υ	Ν	46. Glaucoma?	Υ	Ν
7. Congenital Heart Disease (CHD)?* Y N 49. Autism? Y N 8. Cardiac transplantation?* Y N 50. ADD/ADHD? Y N 9. Intravascular Access Device?* Y N 51. Fibromyalga? Y N N 10. Rheumatic heart disease or Rheumatic fever? Y N 53. Gout? Y N 11. Scarlet fever? Y N 53. Gout? Y N 11. Scarlet fever? Y N 54. Multiple Sclerosis (MS)? Y N 12. Heart defect, heart murmur or mitral valve prolapse? Y N 56. Chronic fatigue? Y N 13. Congestive heart failure? Y N 57. Hemophilia? Y N 14. Heart trouble, heart attack, or angina? Y N 15. Pacemaker? Y N Do you have any disease, condition, or problem 16. Heart surgery? Y N 17. N Do you have any disease, condition, or problem 16. Heart surgery? Y N 17. N Do you have any disease, condition, or problem 17. Emphysema? Y N 18. High Cholesterol? Y N 19. Stroke? Y N 19. Strok	5. Prosthetic cardiac valve?*	Υ	Ν		Υ	Ν
8. Cardiac transplantation?*	6. Cardiac valve repair?*	Υ	Ν	48. Psychiatric treatment?	Υ	Ν
9. Intravascular Access Device?* Y N 51. Fibromyalga? Y N 10. Rheumatic heart disease or Rheumatic fever? Y N 53. Gout? Y N 11. Scarlet fever? Y N 53. Gout? Y N 11. Scarlet fever? Y N 54. Multiple Sclerosis (MS)? Y N 12. Heart defect, heart murmur or mitral valve prolapse? Y N 56. Chronic fatigue? Y N 13. Congestive heart failure? Y N 57. Hemophilia? Y N 14. Heart trouble, heart attack, or angina? Y N 15. Pacemaker? Y N Do you have any disease, condition, or problem 16. Heart surgery? Y N not listed above that you think we should know 17. Emphysema? Y N of? Y N 19. Stroke? Y N 19. St	7. Congenital Heart Disease (CHD)?*	Υ	Ν	49. Autism?	Υ	Ν
10. Rheumatic heart disease or Rheumatic fever?	8. Cardiac transplantation?*	Υ	Ν	50. ADD/ADHD?	Υ	Ν
fever? Y N 53. Gout? Y N 11. Scarlet fever? Y N 54. Multiple Sclerosis (MS)? Y N 12. Heart defect, heart murmur or mitral valve prolapse? Y N 56. Chronic fatigue? Y N 13. Congestive heart failure? Y N 57. Hemophilia? Y N 14. Heart trouble, heart attack, or angina? Y N 15. Pacemaker? Y N Do you have any disease, condition, or problem not listed above that you think we should know of? N 16. High Cholesterol? Y N Of? Y N 17. Emphysema? Y N Of? Y N 18. High Cholesterol? Y N 19. Stroke? Y N 20. High blood pressure? Y N 21. Low blood pressure? Y N 22. Nasal obstruction? Y N recommended that you take antibiotics prior to your dental treatment? Y N 23. Cold sores? Y N If yes, what antibiotic and dose Y N 24. Steroid treatment? Y N If yes, what antibiotic and dose Y N	9. Intravascular Access Device?*	Υ	Ν	51. Fibromyalga?	Υ	Ν
11. Scarlet fever? Y N 54. Multiple Sclerosis (MS)? Y N 12. Heart defect, heart murmur or mitral valve prolapse? Y N 56. Chronic fatigue? Y N 13. Congestive heart failure? Y N 57. Hemophilia? Y N 14. Heart trouble, heart attack, or angina? Y N 15. Pacemaker? Y N Do you have any disease, condition, or problem 16. Heart surgery? Y N 17. Molecular troubles above that you think we should know 17. Emphysema? Y N 19. Stroke? Y N 19.	10. Rheumatic heart disease or Rheumatic			52. GERD?	Υ	Ν
12. Heart defect, heart murmur or mitral valve prolapse?	fever?	Υ	Ν		Υ	Ν
valve prolapse?	11. Scarlet fever?	Υ	Ν		Υ	Ν
13. Congestive heart failure? Y N 57. Hemophilia? Y N 14. Heart trouble, heart attack, or angina? Y N 15. Pacemaker? Y N Do you have any disease, condition, or problem 16. Heart surgery? Y N not listed above that you think we should know 17. Emphysema? Y N of?	12. Heart defect, heart murmur or mitral			55. Eating disorder?	Υ	Ν
14. Heart trouble, heart attack, or angina? 15. Pacemaker? 16. Heart surgery? 17. Emphysema? 18. High Cholesterol? 19. Stroke? 19. Stroke? 10. High blood pressure? 11. Low blood pressure? 12. Low blood pressure? 13. V N 14. Steroid treatment? 15. Pacemaker? 16. Y N 17. Do you have any disease, condition, or problem 18. not listed above that you think we should know 19. Stroke? 19. V N 19. Stroke? 10. W N 11. High blood pressure? 11. V N 12. Low blood pressure? 12. Nasal obstruction? 13. Cold sores? 14. V N 15. V N 16. Heart trouble, heart attack, or angina? 15. No pour dental treatment? 16. Heart surgery? 17. N 18. High Cholesterol? 18. High Cholesterol? 19. N 19. Stroke? 19. N 10. High blood pressure? 19. N 10. Has a physician or previous dentist 10. Trecommended that you take antibiotics prior to 10. V N 11. If yes, what antibiotic and dose	valve prolapse?	Υ	Ν	56. Chronic fatigue?	Υ	Ν
15. Pacemaker?	13. Congestive heart failure?	Υ	Ν	57. Hemophilia?	Υ	Ν
16. Heart surgery?	14. Heart trouble, heart attack, or angina?	Υ	Ν			
17. Emphysema? Y N of? 18. High Cholesterol? Y N 19. Stroke? Y N 20. High blood pressure? Y N 21. Low blood pressure? Y N *Has a physician or previous dentist 22. Nasal obstruction? Y N recommended that you take antibiotics prior to 23. Cold sores? Y N your dental treatment? Y N 24. Steroid treatment? Y N If yes, what antibiotic and dose	15. Pacemaker?	Υ	Ν	Do you have any disease, condition, or problem		
18. High Cholesterol?	16. Heart surgery?	Υ	Ν	not listed above that you think we should know		
18. High Cholesterol?	17. Emphysema?	Υ	Ν	of?		
20. High blood pressure?	18. High Cholesterol?	Υ	Ν			
21. Low blood pressure?YN*Has a physician or previous dentist22. Nasal obstruction?YNrecommended that you take antibiotics prior to23. Cold sores?YNyour dental treatment?YN24. Steroid treatment?YNIf yes, what antibiotic and dose	19. Stroke?	Υ	Ν			
22. Nasal obstruction? Y N recommended that you take antibiotics prior to 23. Cold sores? Y N your dental treatment? Y N 24. Steroid treatment? Y N If yes, what antibiotic and dose	20. High blood pressure?	Υ	Ν			
23. Cold sores?	21. Low blood pressure?	Υ	Ν	*Has a physician or previous dentist		
24. Steroid treatment?	22. Nasal obstruction?	Υ	Ν	recommended that you take antibiotics prior to		
•	23. Cold sores?	Υ	Ν	your dental treatment?	Υ	Ν
25. Hearing loss?	24. Steroid treatment?	Υ	Ν	If yes, what antibiotic and dose		
	25. Hearing loss?	Υ	N			

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.

Х		
	Signature of Patient or parent/guardian if minor	Date