Brownsburg Dental Professionals PC **1040 Patrick PL STE B** **Brownsburg, IN 46112**
Ph: 317-852-9787 Fax: 317-852-5725

Dental and Medical History

Date: _____

Name:_____ Date of Birth:_____

Address:_____ City:_____ Zip:_____

Phone: (_____)_____ _____ Cell:(_____)_____ _____ Email: _____

If you are completing this form for another person, Your name:_____

What is your relationship to this person?_____

I consider my health to be (please circle): **Excellent** **Good** **Fair**

Check all that apply:

_____ Abnormal Blood Pressure, If yes circle: (High Low)	_____ Herpes
_____ AIDS/HIV	_____ Hx of Chemotherapy Radiation Treatment
_____ Alzheimer's/Dementia	_____ High Cholesterol
_____ Anemia	_____ Immune Suppressed Disorder/Autoimmune Disease
_____ Asthma / Hay Fever	_____ Implants/Artificial Joints
_____ Arthritis	Check: Knee ___ Hip ___ Shoulder____ Other __
_____ Cancer, Tumor, or Malignancy	_____ Infectious Mononucleosis (Mono
_____ Cardiovascular Disease	_____ Jaundice
_____ Congenital Heart Lesions	_____ Kidney Disease
_____ COPD	_____ Liver Disease/Hepatitis , Type : ____
_____ Defibrillator/ Pacemaker	_____ Multiple Sclerosis
_____ Diabetes	_____ Osteoporosis
_____ Drug or Alcohol Addiction	_____ Prolonged Bleeding (ie Blood Thinners)
_____ Emotional/ Nervous Disorder (ie: anxiety)	_____ Prostate Problems
_____ Epilepsy / Seizures	_____ Sexually Transmitted/ Venereal Disease
_____ Excessive Urination/ Thirst	_____ Sinus Trouble
_____ Fainting Spells	_____ Stomach ulcers/ G.E.R.D
_____ Glaucoma	_____ Stroke
_____ Hayfever	_____ Thyroid Issues
_____ Hearing Loss	_____ Tuberculosis /Lung Disease
_____ Heart Murmur	_____ Vascular Disorders

Do you smoke or use tobacco Products? _____ If so, How often? _____ How many years?_____

Physician's Name: _____ Phone:_____ Address:_____

Are you allergic to any of the following? (check all that apply)

____ Aspirin _____ Ibuprofen _____ Sulfa Drugs/Sulfites/Sulfides _____Penicillin _____Codeine

____Latex/Metals/Plastics _____ Other Medications, If so, which ones:_____

Women: Are you pregnant? _____ If yes, Due Date: _____ Are you currently nursing?_____
Are you taking birth control medication?_____

Have you ever been Hospitalized? _____ If so, Please list procedure/s and Dates:_____

_____

_____

Please List ALL medications (prescribed and OTC) you are currently taking: (can provide a separate list)

Medicine:_____ Reason :_____ Medicine:_____ Reason :

Medicine:_____ Reason :_____ Medicine:_____ Reason :_____

Medicine:_____ Reason :_____ Medicine:_____ Reason :_____

Any Dental concerns/issues today?_____ if so, explain:_____

Have you ever had a reaction to any Dental Treatments? _____ IF so explain: _____

Have you ever had a complication or illness following dental treatments? _____ if yes, Explain: _____

_____

Do you take or have been advised to take antibiotics prior to dental treatment? _____ If yes, Why and By whom?_____

_____

If there anything in your Dental History you feel we should be aware of? _____

_____

If you were to have an emergency situation in our office whom should we contact?

Name:_____ Phone:_____

How often do you Brush?_____ How often do you Floss? _____

Check all that apply:

_____ Bad Breath	____ Grinding Teeth	____ Sensitivity to Hot
_____ Bleeding gums	____ Loose Teeth/Broken Teeth/fillings	____ Sensitivity to sweets
_____ Clicking or popping Jaw	____ Periodontal Treatment	____ Sensitivity when biting/chewing
_____ Food collecting between teeth	____ Sensitivity to cold	____ Sore Gums/growths in mouth

Emergency Information: (NOT living with you)

Name:_____ Phone: (_____)_____ Other phone:(_____)_____

Address_____

Please Read the following and sign below:

Before treatment can be rendered, adequate dental radiographs must be taken.

We reserve the right to charge for appointments cancelled or broken appointments without a 24 hr (1 business day) advanced notice.

I, _____ have answered all the proceeding questions to the best of my knowledge and consent to the performing dental and oral surgery procedures agreed to be necessary or advisable including the use of anesthetic as indicated and I will assume responsibility for fees associated with those procedures (including if warranted: late fees, collection agency fees, and cancelled or missed appointment fees)

Signature: _____ Date:_____