Dentist: _____ Date: _____-___-___

Patient profile:					
Last name:	*	**Middle name**:		**First name**:	*
Date of birth:	* *Input in yyyy mm dd*				
Nationality:	*				
Passport #:					
Marital status:	0 Single 0 Married 0 Widow(er) 0 Separated				
Patient adress(es):					
Home address	0 Yes 0 No				
House #:	*	**Street**:	*	**District**:	
City:	*	**Province**:			
Postal code:	*				
Country:	*				
Phone #:					
Mobile #:					
Email address:					
Email address 2:					
Guardian home address	0 Yes 0 No				
House #:	*	**Street**:	*	**District**:	
City:	*	**Province**:			
Postal code:	*				
Country:	*				
Phone #:					
Mobile #:					
Email address:					
Email address 2:					
Office address	0 Yes 0 No				
Company name:	*				
House #:	*	**Street**:	*	**District**:	
City:	*	**Province**:			
Postal code:	*				
Country:	*				
Phone #:					
Mobile #:					
Email address:					
Guardian office address	0 Yes 0 No				
Company name:	*				
House #:	*	**Street**:	*	**District**:	

City:	*	**Province**:	
Postal code:	*		
Country:	*		
Phone #:			
Mobile #:			
Email address:			
Patient insurer details:			
Insurer:			
		If the patients insurer is Not listed, please fill in here	
Policy #:			

Dentist: _____ Date: _____-___-___

Medical history:					
Name of Physician: Dr.		**Specialty, if applicable**:			
Office address					
Building name:		**Office #**:			
House #:		**Street**:		**District**:	
City:		**Province**:			
Postal code:					
Country:					

1. Are you in good health?	0 Yes 0 No
2. Are you under medical treatment now?	0 Yes 0 No
If so, what is the condition being treated?	
3. Have you ever had serious illness or surgical operation?	0 Yes 0 No
If so, when and for what illness or operation?	
4. Have you ever been hospitalized?	0 Yes 0 No
If so, when and why?	
5. Are you taking any prescription / 0 Non-prescription medication?	0 Yes 0 No
If so, please specify, include dosage and frequency:	
6. Do you use tabacco products?	0 Yes 0 No
If so, please specify:	
0 Yes 0 No	
If so, please specify:	

8. Are you allergic to any of the following?	0 None of the list allergies are applicable to the patient		
	0 Local Anesthetic (ex. Lidocaine)	0 Penicillin Antibiotics	
	0 Sulfa drugs	0 Asprin	0 Latex
	0 Other:		
9. Bleeding time:	min(s)		
10. For women only: Are you pregnant?	0 Yes 0 No		
If so, for what term?			
Are you nursing?	0 Yes 0 No		
Are you taking birth control pills?	0 Yes 0 No		
If so, for how long?			
11. Blood type:			
12. Blood pressure:	/		

13. Do you have or have you had any of the following?

0 None of the list items are applicable to the patient		
0 High Blood Pressure	0 Heart Disease	0 Cancer / Tumors
0 Low Blood Pressure	0 Heart Mummur	0 Anemia
0 0 Epilepsy / Convuisions	0 Hepatitis Liver Disease	0 Angina
0 AIDS or HIV Infection	0 Rheumic Fever	0 Asthma
0 Sexually Transmitted Disease	0 Hay Fever Allergies	0 Emphysema
0 Stomach Troubles / Ulcers	0 Hapetitus / Liver	0 Bleeding Problems
0 Fainting Spells	0 Hepatitis / Jaundice	0 Blood Diseases
0 Rapid Weight Gain / Loss	0 Tuberculosis	0 Head Injuries
0 Radiation Therapy	0 Swollen ankles	0 Arthritis / Rheumatism
0 Joint Replacement / Implant	0 Kidney Disease	0 Other:
0 Heart Surgery	0 Diabetes	
0 Heart Attack	0 Chest pain	
0 Thyroid Problem	0 Stroke	

14. Comment:

Dentist: _____ Date: ____-__-__

Dental history:			
Gingivae:	0 Healthy 0 Midly Inflamed 0 Severely Imflamed	**Oropharynx**:	

Teeth:	0 Cracked	**Teeth discoloration**:	0 Intrensic 0 Extrensic
	0 Sensitive to sweet	**Calculus**:	0 Slight 0 Moderate 0 Heavy
	0 Sensitive to sour food	**Tongue**:	*small, large, red, pink, etc.*
	0 Sensitive to drinks	**Malocclusion**:	0 Class I 0 Class II Class III
	0 Sensitive to percussion	**Mentalis**:	
	0 Sensitive to hot or cold food or drink	**Swallowing**:	
Palate:		**Gag flex**:	
Frenum:		**Habits**:	0 Drinks tea, coffee, or wine
Profile:	0 Class I 0 Class II 0 Class III		0 Smokes / uses tobacco products
Hygiene:	0 Good 0 Fair 0 Bad	**Complications**:	0 Bleeds when brushing or flossing
Abrasions:			0 Bleeds profusely after tooth extraction
Receded gums:			0 Delayed healing after tooth extraction
Mouth opening:	mm		
Prev dentist:		**Contact #**:	
Comment: Make a brief summery of the overall condition			