Granville
Dental Wellness

INFORMATION UPDATE FOR PATIENT INFORMATION, MEDICAL AND DENTAL HISTORY

PATIENT'S NAME | **DATE OF BIRTH (MM/DD/YY)** | **Gender** ☐ F ☐ M

Last First Middle

PATIENT'S ADDRESS | **Home Phone #** | **Cell phone #** | **Work Phone #**

Email Address

By which way do you prefer to communicate with us?
(Check more than one choices if necessary)
☐ **Home #** ☐ **Cell #** ☐ **Work #** ☐ **Text** ☐ **Email**

MEDICAL HISTORY UPDATE

Office Only: BP ____ Pulse ____ ASA type ____ YES NO

1. Most Recent Medical Exam Date ____ and Summaries ____
2. Do you take or have you been recently advised to take antibiotics prior to dental treatment?---------- ◯ ◯
3. Please list your known allergies ____
4. Have you recently been diagnosed with heart conditions such as heart attack, high blood pressure, stroke etc.-- ◯ ◯
   - If yes, please summarize ____
5. Have you been diagnosed with hepatitis A, B, or C?---------- ◯ ◯
6. Have you been diagnosed with HIV? ---------- ◯ ◯
7. Have you been treated with chemotherapy, radiation therapy or bisphosphonate therapy?---------- ◯ ◯
8. Have you been diagnosed with diabetes? ---------- ◯ ◯
   - If yes, glucose level ____ or Hemoglobin A1c level ____
9. Do you have artificial joints or hips? ---------- ◯ ◯
   - If yes, please let us know the date of surgery ____
10. Female only: Are you pregnant or planning a pregnancy? ---------- ◯ ◯
11. Female only: Are you breast-feeding? ---------- ◯ ◯
12. Describe any current medical treatment, impending surgery or other treatment that may possibly affect your dental treatment. ____
13. List all medications, supplements, and or vitamins taken within last two years (This information is important even if you have already informed us at your last appointment to prevent adverse drug reactions)

Drug	Purpose	Drug	Purpose

DENTAL HISTORY UPDATE

YES NO

14. Are you interested in tooth whitening or cosmetic treatment to improve your current smile?---------- ◯ ◯
15. Are you self-conscious about your teeth or smile? ---------- ◯ ◯
16. Is there anything about the appearance of your teeth that you would like to change?---------- ◯ ◯
    - If yes, please describe for us ____
17. **Do you have problems with your jaw joint (pain, sound, limited opening, locking, popping?** ---------- ◯ ◯
18. **Do you feel like your lower jaw is being pushed back when you bite your teeth together?** ---------- ◯ ◯
19. **Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, protein bars, or other hard, dry food?**------ ◯ ◯
20. **Have your teeth changed in the last 5 years, become shorter, thinner, or worn?**---------- ◯ ◯
21. **Are your teeth crowding or developing spaces?**---------- ◯ ◯
22. **Do you have more than one bite and squeeze to make your teeth fit together?**---------- ◯ ◯
23. **Do you chew ice, bite your nails, use your teeth to hold object or have any other oral habits?**---------- ◯ ◯
24. **Do you clench your teeth in the daytime or make them sore?**---------- ◯ ◯
25. **Do you have any problems with sleep or wake up with an awareness of your teeth?** ---------- ◯ ◯
26. **Do you wear or have you ever worn a bite appliance?**---------- ◯ ◯
27. How often do you Brush **a day**? ____ and floss **a week** ____
28. Do you use an electric tooth brush? ---------- ◯ ◯
29. Please discuss any other concerns with or problems about your teeth, smile, or eating below?

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Thank you very much for taking the time to fill in this form which helps us to treat you safely and comfortably!