GWD
GOLDWATER DENTAL

implant, cosmetic, restorative dentistry

MEDICAL & DENTAL HISTORY

Patient Name: _____

Date of Birth: _____/_____/_____

DENTAL HISTORY

Date of last dental visit: _____

I'm here…..

- ☐ for a general check-up and have no specific concerns
- ☐ because of recent discomfort, sensitivity, or pain and have a specific concern
- ☐ I would like to discuss functional or cosmetic changes to my smile

Check if you have had any of the following:

- ☐ bad breath
- ☐ bleeding gums
- ☐ clicking or popping jaw
- ☐ grinding teeth
- ☐ loose teeth or broken fillings
- ☐ cold sores
- ☐ sensitivity to hot/cold
- ☐ headaches
- ☐ history of deep cleanings
- ☐ history of dental trauma
- ☐ history of braces

MEDICAL HISTORY

Please answer the questions below by circling yes or no:

Have you had any surgical operations or hospitalizations?	Yes	No
Have you ever had a joint replacement?	Yes	No
Do you take any blood thinner (Coumadin, Warfarin, Plavix, etc)	Yes	No
Do you take daily Aspirin®?	Yes	No
Do you have osteoporosis or take Fosamax®, Boniva®, or similar drug?	Yes	No
Have you ever had cancer or received chemotherapy/radiation?	Yes	No
Have high blood pressure?	Yes	No

Please list any medication you are currently taking or have been prescribed by a physician:

_____

_____

Please indicate if you have or have you had:

Heart disease	Yes No	Hepatitis	Yes No
Heart attack	Yes No	HIV/AIDS	Yes No
Heart murmur	Yes No	Stomach ulcers	Yes No
Rheumatic fever	Yes No	Skin disease	Yes No
Stroke	Yes No	Anemia	Yes No
Asthma	Yes No	Blood disorder	Yes No
TB, emphysema	Yes No	Diabetes	Yes No
Pacemaker	Yes No	Artificial heart valve	Yes No

Women:

Are you pregnant or trying to get pregnant?	Yes No
Nursing?	Yes No
Taking birth control?	Yes No

Please list any allergies to drugs, antibiotics, aspirin, sulfa, or local anesthetic:

_____

The above information is accurate and complete to the best of my knowledge. I will inform Dr. Jensen of any changes in my health or medications. I will not hold MINT. liable for any errors or omissions I have made in the completion of this form.

Patient Signature:_____ Date:_____/_____/_____