KELLEY L. BORDERS, D.M.D.

Medical and Dental History

Name: ________________ **DOB:** ________________ **Today's Date:** ________________

Are you under a physician's care now? Yes No Doctor's Name: ________________

Phone: ________________

Have you ever been hospitalized? Yes No Reason: ________________

Have you had a major operation? Yes No What Type: ________________

Have you had a serious head or neck injury? Yes No When: ________________

Are you taking any medications, pills, or drugs? Yes No: If yes, please list the medications, pills, or drugs:

Have you ever taken Phen-Fen or Redux? Yes No When: ________________

Have you ever taken bisphosphonates? Yes No When: ________________
(Fosamax, Boniva, Actonel, Zometa)

Are you on a special diet? Yes No Reason: ________________

Do you use tobacco? Yes No Type/Amount: ________________

Do you use controlled substances? Yes No Type/Amount: ________________

Dental History

Are you happy with your past dental visits? Yes No If no, Why? ________________

Do you have any fear of dental work? Yes No Please Circle: Slight Moderate Severe

Do your gums bleed when brushing or flossing? Yes No

Do you feel you have bad breath? Yes No

Would you like your teeth to be whiter? Yes No

Do you have trouble opening or closing your jaw? Yes No Please Circle: Opening Closing

Would you like to improve your smile? Yes No If yes, How? ________________

Have you ever had braces? Yes No

When was your last dental cleaning? ________________

Have you ever had a reaction to any dental anesthetic? Yes No If yes, What? ________________

How did you hear about our office? (Please Circle)

Online Search Website / Insurance Walk-in/Drive By

Friend / Family: ________________ Other: ________________

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Medical History

(Women Only) Are you Pregnant/Trying to get Pregnant? ____ Nursing? ____ Taking oral contraceptives? ____

Circle *if you are* ***Allergic*** *to any of the following:*

Aspirin	Penicillin/Amoxicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Please List any other Allergies: ____

Circle *if you have any of the following* ***Medical Concerns****:*

AIDS/HIV positive	Hepatitis A	Hepatitis B or C	Drug Addiction
Herpes/Cold Sores	Diabetes	Excessive Thirst	Swelling of Limbs
Shingles	Recent Weight Loss	Sinus Troubles	Frequent Cough
Breathing Problems	Easily Winded	Asthma	Anemia
Excessive Bleeding	Blood Transfusion	Emphysema	Lung Disease
Thyroid Disease	Parathyroid Disease	Liver Disease	Stomach Disease
Sickle Cell Disease	Alzheimer's Disease	High Blood Pressure	Low Blood Pressure
High Cholesterol	Scarlet Fever	Hypoglycemia	Hemophilia
Renal Dialysis	Anaphylaxis	Epilepsy or Seizures	Angina
Rheumatic Fever	Rheumatism	Tuberculosis	Yellow Jaundice
Kidney Problems	Osteoporosis	Artificial Heart Valve	Mitral Valve Prolapse
Tumor or Growths	Congenital Heart Disorder	Heart Murmur	Heart Pacemaker
Heart Attack/Failure	Irregular Heartbeat	Leukemia	Cancer
Radiation Treatments	Chemotherapy	Fainting Spells/Dizziness	Stroke
Psychiatric Care	Bruise Easily	Glaucoma	Frequent Headaches
Arthritis/Gout	Chest Pains		

Do you have a medical concern not listed? Please explain: ______________________________

Additional comments: ____

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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 health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

X________________________________ Date: ____________________