Origins Specialty Dentistry
General | Periodontics | Implant | Prosthodontics

Medical/Dental History - New Patient

Last Name: First Name: Birthdate:

Reason for visit / Main Concern? ☐Check-up ☐Toothache ☐Other _____

Date of last dental visit? What treatment was performed? _____

Date of last cleaning? _____ Unusual reaction to dental injections? _____

When were your last dental radiographs taken? _____ Any history of periodontal (gum) treatment? _____

Have you had prolonged bleeding or any problems with past dental treatment? _____

Do you grind your teeth or have any symptoms near your ears such as clicking, popping, pain or locking jaw?

_____

Are your teeth sensitive to hot/cold? _____ Do your gums bleed easily? _____

Are you happy with your smile? _____ Would you like your teeth whiter? _____

Emergency Contact _____ Relationship _____ Phone _____

Name of Medical Doctor: _____ Phone _____

List all medications that you are taking at this time:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Other: _____

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Cancer	☐	☐	Liver Disease
☐	☐	Chemo/ Radiation Therapy	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Psychiatric Care
☐	☐	Heart Murmur	☐	☐	Sinus Trouble
☐	☐	Heart Trouble/ Heart Attack or Surgery	☐	☐	Stroke
☐	☐	Artificial Heart Valve	☐	☐	Ulcers
☐	☐	Pacemaker	☐	☐	Rheumatic Fever
☐	☐	High Blood Pressure	☐	☐	Arthritis
☐	☐	Anemia	☐	☐	AIDS/ HIV +
☐	☐	Bleeding Problems	☐	☐	Dizzy Spells/ Vertigo
☐	☐	Thyroid Problems	☐	☐	Epilepsy/ Seizure
☐	☐	Drug Addiction	☐	☐	Fainting
☐	☐	Lung Disease	☐	☐	Glaucoma
☐	☐	COPD/ Emphysema	☐	☐	Joint Replacement
☐	☐	Hepatitis	☐	☐	Sleep Apnea
☐	☐	Tuberculosis (TB)	☐	☐	TMJ Disroders (TMD)
☐	☐	COVID-19	☐	☐	Venereal Disease
☐	☐	History of Bisphosphonate Therapy/ Antiresorptive or Antiangiogenic Medications			

Smoking, tobacco use or any recreational drugs? If so, what kind and how much? _____

(Women) Are you nursing? _____ If pregnant, how many months? _____

To the best of my knowledge, I have answered the questions completely and accurately. I will inform my dentist of any changes in my health and/or medications. I further certify that I consent to taking x-rays and oral examination.

Date: Signature