Icon Dental Center Annual Update

PATIENT NAME ____ **DOB**_____/______/_____

MAILING ADDRESS____________________________________ **CITY**_____________ **ZIP CODE** ___________

PHONE NUMBER (______)______-_______

Do you have any immediate concerns/pain? ____

Please circle YES or NO if you have, or ever had the following:

Unhappy with appearance of your teeth	**YES | NO**	Burning sensation in the mouth	**YES | NO**
Unfavorable dental experience/fear	**YES | NO**	Difficulty swallowing	**YES | NO**
Preference for no dental anesthetic	**YES | NO**	Unpleasant taste or odor in your mouth	**YES | NO**
Difficulty/Reactions to dental anesthetic	**YES | NO**	Jaw problems/pain/clicking/locking	**YES | NO**
Orthodontic treatment/Braces	**YES | NO**	Difficulty opening wide	**YES | NO**
Periodontal (Gum) treatment	**YES | NO**	Stiff neck muscles	**YES | NO**
Bleeding Gums	**YES | NO**	Tension headaches	**YES | NO**

ALLERGIES ***mark all that may apply***

ASPIRIN, ACETAMINOPHEN, or IBUPROFEN___ PENICILLIN___ OTHER ANTIBIOTICS___ CODEINE/NARCOTICS___

LATEX___ FLUORIDE___ LOCAL ANESTHESIA___ METALS___ SULFA___ OTHER ______________________________

MEDICAL INFORMATION

Physician or Clinic name ____________________________________ Phone (______) ________ - _________

Please circle YES or NO if you have, or ever had the following;

Anemia	**YES | NO**	Cough up blood	**YES | NO**	Narcolepsy	**YES | NO**
Angina	**YES | NO**	Diabetes	**YES | NO**	Kidney Disease	**YES | NO**
Anxiety	**YES | NO**	Epilepsy	**YES | NO**	Liver Disease	**YES | NO**
Arthritis	**YES | NO**	Fainting	**YES | NO**	Mitral Valve Prolapse	**YES | NO**
Artificial joint/heart valve	**YES | NO**	Fatigue	**YES | NO**	Pacemaker	**YES | NO**
Anemia or blood disorder	**YES | NO**	GERD	**YES | NO**	Radiation therapy	**YES | NO**
Asthma	**YES | NO**	Headaches	**YES | NO**	Respiratory Disease	**YES | NO**
Back problems	**YES | NO**	Heart attack	**YES | NO**	Sleep Apnea	**YES | NO**
Blood disease	**YES | NO**	Heart Murmur	**YES | NO**	Stroke	**YES | NO**
Chemical dependency	**YES | NO**	Hemophilia	**YES | NO**	Thyroid Problems	**YES | NO**
Glaucoma	**YES | NO**	Hepatitis	**YES | NO**	Tuberculosis	**YES | NO**
Chemotherapy	**YES | NO**	High blood pressure	**YES | NO**	Ulcer	**YES | NO**
Cancer	**YES | NO**	HIV/AIDS	**YES | NO**		

Have you had any serious type of illness or operation? ________ If Yes describe: ____

If you have a disease, condition or problem not previously listed, please describe: ____

____

Have you ever taken Fosamax, Boniva, Actonel, or any other cancer medications? **YES | NO**

Do you use tobacco? **YES | NO** Has your Doctor ever told you that you require a Pre-Medication? **YES | NO**

(Women) Are you currently pregnant or trying to? **YES | NO** Nursing? **YES | NO**

Please list any/all medications your are currently taking; ____

____

____

Patient Signature____ Date ____/____/______

Dentist signature ____