Patient's Name:

Jamison S. Cox DMD
Family Dental
(435) 673-2491

Medical History

Physician's Name:

Phone: Date of last visit:

Your current health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under care of a physician? ☐ Yes ☐ No

Please explain:

Do you currently take any prescription and/or over the counter drugs? ☐ Yes ☐ No

Please list each:

Please check any medications you are allergic to:

☐ Penicillin ☐ Sulfa ☐ Acetaminophen ☐ Ibuprofen

☐ Aspirin ☐ Latex ☐ Codeine

Please list/describe any other allergies:

Have you ever had any of the following diseases/conditions or used any of the following products?

☐ High Blood Pressure
☐ Low Blood Pressure
☐ Heart attack/Blood problems
☐ Immune System Disorders
☐ Stroke
☐ Heart Murmur
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Rheumatic Fever
☐ Heart Surgery
☐ Artificial Valves
☐ Congenital Heart Defect
☐ Hemophilia/Abnormal Blood
☐ Blood Transfusion
☐ Cancer/Chemotherapy
☐ Radiation Treatment
☐ Rheumatism
☐ Arthritis
☐ Artificial Bones/Joints
☐ Fosamax/Actone/Boniva

☐ Diabetes ☐ I ☐ II
☐ Hepatitis ☐ A ☐ B ☐ C
☐ Ulcers
☐ Colitis
☐ Kidney/Liver Problems
☐ Respiratory Problems
☐ Asthma
☐ Tuberculosis (TB)
☐ Fever Blisters/Cold Sores
☐ Glaucoma
☐ Epilepsy
☐ Seizures
☐ Fainting Spells
☐ Nervous Breakdown
☐ Psychiatric Treatment
☐ Hospitilization
☐ STD
☐ HIV/AIDS
☐ Drug/Alcohol Abuse
☐ Tobacco - Smoke/Chew

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Dental History

Date of last dental visit:

Date of last full mouth/pano x-ray:

Why have you come to the dentist today?

Are you currently in pain? Explain. ☐ Yes ☐ No

What is most important about your dental health?

Have you had a serious or difficult problem associated with previous dental work? Explain. ☐ Yes ☐ No

Are you happy with your previous dental work? Explain.

Do you or have you ever had issues with your jaw joint? (TMJ Disorder) ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss?

How many times a day do you brush?

Are there any services or products in which you are particularly interested? Specific questions you would like Dr. Cox to address?

Do you have any dental or medical conditions not addressed on this form? Explain.

I certify that I have answered all questions on this form accurately to the best of my knowledge.

Signed:

Relation: Date: