1149 Bloomfield Ave Suite A
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Patient Name:_____

MEDICAL HISTORY

Please circle (Y) for "yes", or (N) for "no" for any of the following which may apply to you now, or in the past:

Y N Heart Attack or Heart Trouble	Y N Implant or Artificial Joint	Y N Thyroid Disease	Y N Headaches or Migraines
Y N Congenital Heart Disease	When? _____	Y N Asthma	Y N Epilepsy or Seizures
Y N Chest Pain with exercise (angina)	Y N Anemia or Blood Disorder	Y N Ulcers, Reflux, Heartburn	Y N Tumors, Cancer, Radiation
Y N High Blood Pressure	Y N Excessive Bleeding	Y N Digestive Disorders	Y N Tuberculosis, Lung Problems
Y N Heart Valve Disorder	Y N Diabetes	Y N Kidney Problems	Y N Hepatitis A B C D
Y N Pacemaker	Y N Stroke	Y N Fainting or Blackouts	Y N AIDS or HIV Infection
Y N Psychiatric Disorders	Y N Use Tobacco?	Y N Drug/Alcohol Dependency	

Periodontal disease has been linked to the following, do you have any family history of: (circle any that apply)

Heart Disease Stroke Diabetes Early-Term Birth Cancer Dementia

Are you currently pregnant?_____ If yes when are you expecting?_____

Have you seen a physician or been hospitalized in the last two years (including pregnancy)? Y N

If yes, please explain _____

Physician's name and phone:_____

Have you ever had an allergic reaction to an anesthetic or drug such as **penicillin, sedative, latex, aspirin, or metals**? Y N

If yes, please explain _____

Please list any prescription or over the counter drugs, medications, or vitamins you are currently taking:

Here at Dental Wellness of Clifton we offer a variety of services to enhance your comfort, and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

In Office Whitening	Invisalign	Invisalign
Flouride	Veneers	Extended Payment Plans
Sealants	Implants	Partials/Dentures
Take Home Whitening Trays	Night Guard	Sleep Apnea Appliances

Responsible Party Signature:_____ Date:_____

Doctor/Hygienist Signature:_____ Date:_____