VIDUNAS DENTISTRY

313 MARKET STREET - MIFFLINBURG, PA 17844
570-966-1511
WWW.VIDUNASDENTISTRY.COM

Name:	**Birth Date:**
Address:	**Home Phone Number:** **Cell Phone** **Work**
	SSN#
Dental Insurance/Carrier	**Medical Doctor**
Responsible Party for Account:	

Please Draw A Circle Around Any Of The Following Which You Have Had Or Have At Present.

Heart Disease	Rheumatic Fever	Asthma	Hepatitis
Angina Pectoris	Stroke	Hay Fever	Thyroid Disease
Frequent Chest Pains	Hemophilia	Emphysema	Glaucoma
High Blood Pressure	Bruise Easily	Tuberculosis (TB)	Epilepsy or Seizures
Shortness of Breath	Prolonged Or Unusual Bleeding	Diabetes	Fainting or Dizzy Spells
Swollen Ankles	Anemia	Ulcers	AIDS or AIDS Related Complex
Artificial Heart Valve	Blood Transfusion	Kidney Trouble	HIV Positive
Congenital Heart Disease	Sickle Cell Disease	Liver Disease	Cold Sores
Heart Murmur	Arthritis	Jaundice (Other than at birth)	Genital Herpes
Cancer	Drug Addiction	Unexplained Weight Loss	Venereal Disease (Syphilis, Gonorrhea)
Chemotherapy	Psychiatric Treatment	Radiation Therapy	Implant Prosthesis

CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS. (IF IN DOUBT, CIRCLE YES) (If, YES, please give details. CONTINUE COMMENTS ON BACK IF NECESSARY.

ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER THE CAR OF A PHYSICIAN DURING THE PAST YEAR?	YES	NO
ARE YOU PRESENTLY TAKING ANY MEDICATIONS OR DRUGS?	YES	NO
ARE YOU ALLERGIC TO ANY MEDICINE OR DRUGS?	YES	NO
HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC?	YES	NO
HAVE YOU EVER EXPERIENCED ANY COMPLICATIONS OR ILLNESS FOLLOWING DENTAL TREATMENT?	YES	NO
DO YOU HAVE ANY DISEASES OR CONDITIONS NOT LISTED ABOVE?	YES	NO
HAVE YOU EVER BEEN TOLD YOU WERE NOT ELIGIBLE TO BE A BLOOD DONOR?	YES	NO
DO YOU USE TOBACCO? (If YES, please circle and give frequency) **SMOKE:** Cigarettes Cigars Pipe **SMOKELESS:** Chewing Tobacco Snuff or "Dip" **FREQUENCY:**_______	YES	NO
WOMEN: ARE YOU PREGNANT? (If YES, Please circle trimester block **TRIMESTER 1 2 3**	YES	NO

When was your last dental cleaning and check-up? _________________________

Is there anything you dislike about your teeth? YES NO If Yes, what?_____________________________

Are any of your teeth hurting today? YES NO

Have you ever had any serious problems associated with previous dental treatment? YES NO

If YES, explain:____

Do your gums feel tender or do they bleed when brushing or flossing? YES NO

Do you experience dry mouth? YES NO

Do you clench or grind your teeth at any time? YES NO

Do you wear full Dentures? YES NO UPPER LOWER

Do you wear partial Dentures? YES NO UPPER LOWER

Do you gag easily? YES NO

PATIENT SIGNATURE:____DATE:_____________________

(Parent/Guardian)