WELCOME

Allen K. Langford, DDS, MDS, PC

Patient Name: _____

Please describe your main concerns with your teeth and any information your dentist has given you about possible treatments: _____
_____
_____

- **DENTAL HISTORY**

Please rate your oral health: Good Fair Poor

Yes / No Do you have regular dental check-ups? When was the last check-up? _____

Yes / No Do you clinch/grind your teeth?

Yes / No Have you ever had any pain/tenderness in your jaw joint (TMJ)?

Yes / No Do/did you have any of the following habits?
thumb sucking lip biting speech difficulty nail biting mouth breathing

Yes / No Have you had a blow or trauma to jaw or teeth?
Explain: _____

Yes / No Has any member of your family had braces?
Name and relationship: _____

- **MEDICAL HISTORY**

Please rate your overall health: Good Fair Poor

Yes / No Are your taking any prescription or over-the-counter drugs?
List: _____

Yes / No Are you allergic to any drugs or other substances?
List: _____

Yes / No Have you ever experienced the following medical conditions?

_Abnormal bleeding	_Aids	_Anemia
_Asthma	_Cancer	_Chicken Pox
_Congenital Heart Defect	_Convulsions	_Diabetes
_Epilepsy	_Heart Murmur	_Hemophilia
_Hepatitis	_High Blood Pressure	_HIV+
_Kidney problems	_Low Blood Pressure	_Rheumatic Fever
_Skin rashes	_Tuberculosis (TB)	_Tonsillitis

Yes / No Are there any other medical conditions we need to be aware of?
Explain:_____

Yes / No Has your physician told you that you need to be premedicated with an antibiotic before dental procedures? If yes, what is the medical condition and what is the antibiotic?_____

Contact Information:

Best Number to contact you: _____

Employer: _____ Employer phone #: _____

Emergency Contact Name: _____
Relation to Patient: _____ Phone #: _____
Employer: _____

I understand that this information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes.

Signature: _____ Date:_____