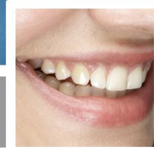
Paragon Dental
1221 Golden Gate Drive
Papillion NE 68046

(402)331-2070
paragondental@rocketmail.com
www.paragondentalinc.com



Medical & Dental History Form

Patient Name: ______ ______ ______ ______
Last | First | MI | Preferred Name

Your Primary Care Physician's name?

______

Please mark any of the following to indicate Yes in response to the question:

- ☐ Has there been any change to your general health within the last year?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ (For Women) Are you pregnant?

If so please explain:

______

Please list all medications you take(prescription, OTC, vitamins and supplements):

______

Do you have any allergies?

______

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Diseases and Conditions

Please indicate if you have experienced any of the following:

- ☐ ADHD/ADD
- ☐ AIDS/HIV Positive
- ☐ Allergies
- ☐ Anemia/Blood Disease
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer
- ☐ Cold sores
- ☐ Diabetes
- ☐ Dizziness/fainting
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Glaucoma/Eye Problem
- ☐ Hay Fever
- ☐ Hearing Aid/Loss
- ☐ Heart Attack
- ☐ Heart Condition
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herpes/Cold Sores
- ☐ High Blood Pressure
- ☐ Kidney/Dialysis
- ☐ Liver Disease
- ☐ Mental Health Dx.
- ☐ Mitral ValveProlapse
- ☐ Nervous Disorders
- ☐ Other
- ☐ Pacemaker
- ☐ Periodontal Disease
- ☐ Pre-medicate
- ☐ Prosthetic Limb
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

Do you have any other diseases or conditions that we should be aware of?

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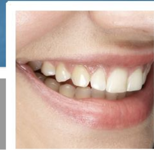

Antibiotic prophylaxis need evaluation

Do you have an artificial heart valve (of any kind)?

○ Yes ○ No

Do you have any artificial joints?

○ Yes ○ No

If yes, please answer the following questions:

How long have you had the prosthetic joint(s)?

Have you had any problems with the joint since it was replaced?

○ Yes ○ No

Your orthopedic surgeon's name/number:

Is your immune system suppressed by disease, medications or treatments?

○ Yes ○ No

Any additional comments:

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Dental Home Care Evaluation/History

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

- [ ] Do your gums generally bleed when you brush or floss?
- [ ] Do your teeth experience sensitivity to cold or hot temperatures regularly?
- [ ] Are any of your teeth currently causing you pain?
- [ ] Do you grind your teeth (either consciously or during sleep)?
- [ ] Are any of your teeth loose, or are you concerned about any teeth loosening?
- [ ] Do you currently have any dental implants, dentures, or partials?

If you could change anything about your mouth, teeth, or smile, what would it be?

I certify that to the best of my knowledge the above information is complete and accurate. If there are any changes in my health, or medicines, I will inform my dentist or his staff at the next appointment. I also grant the right for Paragon Dental to administer such medications and perform diagnostic/ therapeutic procedures as may be necessary for proper dental care.

Signature: ______________________ Date:

Response Date: 5/30/2014