ChrisCozine DDS
Family & Cosmetic Dentistry

Name:_____

Address:_____

_____

Birth Date:_____

Email:_____

Phone Number:_____

Dental History
How long ago/Where was your last dental visit?

_____

Are you having any dental concerns?

_____

Have you ever had a deep cleaning? □ YES □ NO
Do you clench or grind your teeth? □ YES □ NO
Do you wear a night guard? □ YES □ NO
Are you currently having any sinus problems? □ YES □ NO
Have you had any unpleasant dental experiences? □ YES □ NO

Medical History
Are you allergic to latex? □ YES □ NO

Have you had any of the following:
Prosthetic joint (knee or hip) / Prosthetic
Heart valve date: _____ □ YES □ NO
Infective endocarditis □ YES □ NO
Congenital heart disease □ YES □ NO
Cardiac transplant □ YES □ NO

Have you ever been instructed by a
Physician or dentist to *ROUTINELY* take
antibiotics prior to dental procedures? □ YES □ NO
if so why?_____

Have you ever taken any of the following medications?
(Commonly used for osteoporosis and some cancer therapies)
Alendronate (Fosamax)
Risedronate (Aconel)
Zoledronate (Zometa) □ YES □ NO
Ibandronate (Boniva)
Pamidronate (Aredia)
Nerifronate or Olpadronate

Have you had cancer? □ YES □ NO
If yes, what type(s):_____

Signed: Patient or Parent_____

(Women only) Are you pregnant or nursing? □ YES □ NO
Are you taking birth control pills? □ YES □ NO

Please list all medications you are currently taking.
(Continue on back if needed)
Medication: Reason:
_____
_____
_____
_____
_____

Please indicate any medical conditions you have/had:

□ heart problems _____	□ diabetes
□ heart attack date:_____	□ osteoporosis
□ heart surgery date:_____	□ tuberculosis
□ stroke date:_____	□ HIV/AIDS
□ pacemaker date:_____	□ emphysema
□ hepatitis type:_____	□ asthma
□ high blood pressure	□ glaucoma
□ respiratory problems	□ fainting
□ thyroid problems	□ sinusitis
□ bleeding/clotting disorder	□ ulcers
□ seizures -most recent:_____	□ fainting
□ kidney problems	□ migraines
□ inflammatory bowel disease	□ TMJ
□ liver problems	□ STD
□ alcohol/drug abuse	

□ smoke/ chew tobacco (please circle which one)
How long?_____

Check this box if have NONE of the above: □

Please list any other medical condition(s) not listed:
_____
_____
_____
_____

Are you Allergic to any Medications? □ YES □ NO

Please CIRCLE any of the following to which you are allergic or have had an adverse reaction:

Penicillin/Amoxicillin	Clindamycin/Erythromycin
Tylenol	Ibuprofen/Asprin
Codeine	vicodin/lortab/oxycodone
Sulfonamide/Sulfa	Dental Anesthetic
Latex	

Other:_____

Date: _____