Dr. Patrick DelFlore
Medical/Dental History

Dental History:

Reason for today's visit:_____ Date of last dental visit: _____
Date of last dental x-rays:_____
Former Dentist:_____
Address:_____ City:_____ State:____ Zip:_____
Phone Number:_____

Please mark (x) if you have had any of the following:

___ Bad Breath
___Grinding teeth
___Sensitivity to cold/hot
___ Bleeding Gums
___Loose teeth
___ Sensitivity to sweets
___ Clicking or popping Jaw
___Broken teeth
___ Sensitivity when biting
___Periodontal Treatment
___ Sores/growth in mouth
___Orthodontic Treatment
___ Implant Treatment
___TMJ Treatment
___Food collection between teeth

How often do you floss?_____ How often do you brush?_____

Medical History:

Primary care physician: _____ Date of Last Check up: _____
Address: _____City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____

Please mark (x) if you have any of the following:

__Anemia	__Cortisone treatments	__Hepatitis	__Rheumatic Fever
__Arthritis	__Cough, Persistent	__High blood pressure	__Scarlet Fever
__Artificial Heart Values	__Cough up blood	__HIV/AIDS	__Shortness of breath
__Artificial Joints	__Diabetes	__Jaw pain	__Skin Rash
__Asthma	__Epilepsy	__Kidney disease	__Stroke
__Back Problems	__Fainting	__Liver Disease	__ Swelling of Feet
__Blood Disease	__Glaucoma	__Mitral Valve Prolapse	__Thyroid Problem
__Cancer	__Headaches	__Osteoporosis	__Tobacco Habit
__Chemical Dependency	__Heart Murmur	__Pacemaker	__Tonsillitis
__Chemo Therapy	__Heart Problems	__Radiation Treatment	__Tuberculosis
__Circulatory Problems	__Hemophilia	__Respiratory Disease	__Ulcer

Medication:

List medications and dosages you are currently taking:

_____
_____
_____

Allergies:

Please list any allergies or advance reactions you have had:

Medication or substances which caused the allergic reaction?	What kind of reaction did you experience?	When did this reaction first occur?

I certify that the above medical/ dental information is correct.

Signature: _____ Date:_____