



PATIENT INFORMATION/MEDICAL INFORMATION

Name _____

Date of Birth _____

Parent/Guardian Name _____

Home Phone _____

Name of Physician _____

Cell Phone _____

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Plavix (clopidogrel)
<input type="checkbox"/>	<input type="checkbox"/>	Anticoagulants excluding aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Herpes
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders / Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Renal/kidney dialysis
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Disease/Defect	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/heart failure	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy (current)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin/Coumadin
<input type="checkbox"/>	<input type="checkbox"/>	Bisphosphonate therapy (oral or IV)	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone – corticosteroid therapy	<input type="checkbox"/>	<input type="checkbox"/>	Transplants
<input type="checkbox"/>	<input type="checkbox"/>	Artificial full joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	Phen-Fen/Redux
<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus			
<input type="checkbox"/>	<input type="checkbox"/>	Immunocompromised/immunosuppressed			

If answered yes to any of the above, please explain _____

Does patient need to take an antibiotic before dental treatment? NO YES
If yes, why? _____

Current Medications: _____

Allergies (please list): _____

Has the patient been to a dentist in the past year? If yes, reason for visit _____

The following services will be provided free of charge by dental hygiene students from Cape Cod Community College supervised by an instructor: dental screening, oral hygiene instruction, dental prophylaxis/cleaning, fluoride varnish and dental sealants as needed.

If you do not want (your child) to participate in any of the above services, please specify: _____.

Patient/Parent/Court Appointed Guardian Signature _____