CASLER
DENTAL GROUP
6911 South 66th East Avenue - Suite 300
Tulsa, Oklahoma 74133-1748
(918) 477-7677 Fax (918) 493-1991

PATIENT NAME _____ **DATE** _____

DENTAL HISTORY

Yes No

❑ ❑ Do you have a specific dental concern? _____

_____

_____

_____

When was your last dental visit? _____

Date of last dental x-ray, if known _____

❑ ❑ Do you brush on a routine basis?

❑ ❑ Do you floss on a routine basis?

❑ ❑ Do your gums ever bleed?

❑ ❑ Do you use interdental cleaners (e.g., toothpicks, stimudents, proxy brushes)?

Yes No

❑ ❑ Does meat or fibrous foods consistently catch between your teeth?

❑ ❑ Do you ever have clicking, popping, or discomfort in the jaw joint?

❑ ❑ Do you clench or grind?

❑ ❑ Have your past experiences in a dental office always been positive?

❑ ❑ Do you smoke or chew?

How do you feel about the appearance of your smile? _____

_____

_____

_____

MEDICAL HISTORY

What is your primary care physician's name? _____ Phone # _____

Are you now taking, or have you ever taken, any medications for osteoporosis

Bisphosphonates: Actonel, Boniva, Fosomax, Skelid, Didronel? ❑ Yes ❑ No

Aredia, Zometa, Bonefos? ❑ Yes ❑ No

Are you taking any medications? ❑ Yes ❑ No If yes, please list: _____

_____

_____

_____

_____

Have you had an adverse reaction to local anesthetic? ❑ Yes ❑ No

Have you ever taken Phentermine (Phen-Fen), Redux, or Pondimin? ❑ Yes ❑ No Date of last Physical: _____

Are you **allergic** to any medications or substances? ❑ Yes ❑ No If yes, please check box below:

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex Rubber ❑ Sulfa ❑ Other _____

WOMEN (Please check) ❑ Pregnant / trying to get pregnant ❑ Nursing ❑ Using Rx contraceptives Discuss _____

Do you now have or have you ever had any of the following? Please check appropriate boxes.

* Antibiotic premedication may be required.

Yes	No		Yes	No		Yes	No	
❑	❑	Joint Replacement / Prosthesis*	❑	❑	Depression / Bipolar / Anxiety	❑	❑	Acid Reflux
❑	❑	Heart Murmur*	❑	❑	Hemophilia / Excessive Bleeding	❑	❑	Hearing Impairment
❑	❑	Mitral Valve Prolapse*	❑	❑	Leukemia	❑	❑	Allergies (Pollen / Dust)
❑	❑	Rheumatic Fever*	❑	❑	Cancer	❑	❑	Anemia
❑	❑	Heart Pace Maker*	❑	❑	Chemotherapy / Radiation Therapy	❑	❑	Arthritis
❑	❑	Artificial Heart Valve*	❑	❑	Diabetes	❑	❑	Asthma
❑	❑	Heart Surgery*	❑	❑	Hepatitis A (Infectious), B or C	❑	❑	Blood Transfusion
❑	❑	Irregular Heart Beat	❑	❑	Stomach, Liver, or Kidney Disease	❑	❑	Angina
❑	❑	Heart Attack / Failure	❑	❑	Pain in Jaw Joints	❑	❑	Emphysema / COPD
❑	❑	Congenital Heart Disorder	❑	❑	Eating Disorder	❑	❑	Epilepsy / Seizures
❑	❑	Heart Trouble / Disease	❑	❑	HIV Positive / AIDS	❑	❑	Fainting Spells
❑	❑	High Blood Pressure	❑	❑	Cold Sores / Fever Blisters	❑	❑	Hormone Replacement Therapy
❑	❑	Low Blood Pressure	❑	❑	Hyper / Hypothyroidism	❑	❑	Osteoporosis / Osteopenia
❑	❑	Blood Disease	❑	❑	Herpes	❑	❑	Systemic Lupus Erythematosis
❑	❑	Stroke / TIA	❑	❑	Alzheimer's Disease / Dementia	❑	❑	Tuberculosis
❑	❑	Sleep Apnea / Snoring / CPAP Machine	❑	❑	High Cholesterol	❑	❑	Mouth Breathing / Dry Mouth

Have you ever had any other serious illness not checked above? Discuss? _____ ❑ Yes ❑ No

Do you wish to talk to the dentist privately about any problem? _____ ❑ Yes ❑ No

To the best of my knowledge, all the previous answers are correct. If I have any changes in my health or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

x _____ Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)