Abigail H. Mitchell, D.D.S., LLC
Avon Family Dentistry

Name _____ Phone_____ Work_____ Cell _____

Address _____

Age _____ Birth date _____ / _____ / _____ Sex _____ SSN _____

Occupation _____ Employer_____

Emergency contact _____ Phone_____

Physician _____ Address _____ Phone_____

Please circle any of the following which you have or have previously had:

Heart condition	Anemia or Hemophilia	Skin Rashes or Hives	Thyroid Disease	Radiation Treatment
Heart Attack or Stroke	Bruise easily	Kidney Trouble	Cortisone Medication	(X-ray, Cobalt)
Heart Murmur	Shortness of Breath	Diabetes	Glaucoma	Chemotheraphy
Chest Pains (Angina)	Swelling of Ankles	Sickle Cell Disease	Arthritis or Rheumatism	HIV/AIDS
Heart Surgery	Artificial Joints	Liver Disease	Pain in Jaws	Sexually Transmitted Diseases
Artificial Heart Valve	Lung Disease	Hepatitis A	Fainting or Dizzy Spells	Genital Herpes
Heart Pacemaker	Emphysema	Hepatitis B, C, D, E	Alcoholism	Cold Sores
High Blood Pressure	Tuberculosis	Yellow Jaundice	Drug Addiction	Epilepsy or Seizures
Rheumatic Fever	Asthma or Hay Fever	Blood Transfusion	Cancer or Tumor	Psychiatric Treatment

No Yes Do you have any diseases, conditions or medical problems not listed above?
If yes, please explain _____
_____

No Yes Are you presently taking any medications or drugs? If yes, list drug, dosage and frequency _____
_____

No Yes Are you allergic to any medicine, drug or other substance? If yes, please list _____
_____

No Yes Are you now or have been under the care of a medical doctor during the last two years?

No Yes Have you ever been hospitalized or had surgery?

No Yes Have you ever had a reaction to local anesthesia?

No Yes Have you ever had prolonged or unusual bleeding?

No Yes Have you ever had complications or illness following dental treatment?

No Yes Have you ever had an injury or trauma to your face or jaw?

No Yes Do you have a latex allergy?

No Yes Have you ever had brushing/flossing instructions?

No Yes WOMEN: Are you pregnant? Due date _____

No Yes Are you practicing birth control?

No Yes Do you anticipate becoming pregnant?

No Yes Have you had any complications or problems with a pregnancy?

No Yes Do you have pain in or near your ears?

No Yes Do you have any unhealed injuries or inflamed areas in or around your mouth?

No Yes Have you experienced any growths or sore spots in your mouth?

No Yes Does any part of your mouth hurt when clenched?

No Yes Any difficult extractions in the past?

No Yes Have you had prolonged bleeding after extractions?

No Yes Have you ever had gum surgery? If yes, when?
_____

No Yes Do your gums bleed?

No Yes Do you chew on only one side of your mouth?

No Yes Are you happy with the appearance of your smile?

No Yes Do you at the present time have any dental concerns?

No Yes Do you habitually clench your teeth during the night or day?

When and where was your last full mouth x-ray taken?

_____

No Yes Is any part of your mouth sore to pressure, cold or sweets?

If so, where? _____

No Yes Do you smoke or use smokeless tobacco?

No Yes Are you nervous or concerned about having dental work done?

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health or medications, I will inform Avon Family Dentistry.

Signature _____ Date _____