PATIENT INFORMATION/MEDICAL INFORMATION

Name_____ Date of Birth_____

Parent/Guardian Name_____ Home Phone_____

Name of Physician_____ Cell Phone_____

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