Eric T. Moskowitz, DDS
Cosmetic, Implant & General Dentistry

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DENTAL HISTORY

Name: _____ Date of Birth: _____

Purpose of today's dental visit: _____

Date of last dental visit: _____ What was done? _____

Previous dentist:* _____ Phone: _____ Orthodontist?* _____

Does the previous dentist or Orthodontist have xrays? Yes/No* Dates: panorex _____ Bitewings _____

If you have current xrays elsewhere-please have them sent to us PRIOR to your appt. See XRAY Release form.

If we don't have them at yr appt time-we'll need to take new xrays & your insurance may not pay for them.

How do you feel about your teeth in general? _____

What would you do to improve the appearance of your teeth? _____

Check if you have had any of the following:

___ Bad Breath	___ Grinding / clenching teeth	___ Sensitivity to hot
___ Bleeding Gums	___ Loose teeth	___ Sensitivity to sweets
___ Clicking or popping jaw	___ Gum disease treatment	___ Sensitivity to biting
___ Food collecting between teeth	___ Sensitivity to cold	___ Sores / growths in your mouth

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

MEDICAL HISTORY

Physician: _____ Telephone: _____ Last Visit: _____

List any major illnesses within the last five years: _____

Are you pregnant? _____ How far along? _____ Taking Birth Control? _____ Nursing? _____

Preferred Pharmacy: _____ Pharmacy phone #/location: _____

Check if you have had or taken any of the following:

___ Anemia	___ Epilepsy / Seizures	___ Mitral Valve Prolapse
___ Arthritis or Rheumatism	___ Heart Murmur	___ Osteoporosis (circle meds taken)
___ Artificial Heart Valve	___ Heart Problems	___ Fosamax Boniva Acotnel
___ Artificial Joint	Describe: _____	Other Bisphosphonate _____
___ Asthma	___ Hepatitis	___ Pacemaker
___ Back / Neck Problems	___ High / Low Blood Pressure	___ Radiation Treatment
___ Blood Disease	___ H.I.V. / A.I.D.S.	___ Respiratory Disease
___ Cancer	___ Jaundice	___ Rheumatic Fever
___ Chemical Dependency	___ Kidney Disease	___ Stroke
___ Chemotherapy	___ Liver Disease	___ Thyroid Problems ___ Autism
___ Cholesterol high/low	___ Medication for Weight Loss	___ Tobacco habit ___ Aspergers
___ Circulation Problems	___ Phen-Fen ___ Redux	___ Tuberculosis ___ Other
___ Cortisone / Steroid Treatment	___ Sjogrens Syndrome	___ Venereal Disease _____

___ Diabetes ___ Do you have a need to be premedicated for your dental appt? (hip/knee replaced? Heart?)

MEDICATIONS

List ALL medications you are currently taking:

_____

_____

_____

_____

ALLERGIES

___ Aspirin	___ Codeine
___ Local Anesthetic	___ Sulfa Drugs
___ Penicillin	___ Latex

Other : _____

Other: _____

SIGNATURE

The above information is accurate and complete to the best of my knowledge:

Signature: _____ Date: _____

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DOCTOR USE ONLY

Blood Pressure / Reviewed by