INNERBLOOM
DENTAL STUDIO
DR. SARAH ENRIGHT

Patient Name:_____ Today's Date: _____

	YES	NO	DETAILS
Any specific concerns today?			
Do you take any medications? Please list.			
Do you have any health conditions? Please list.			
Do you pre-medicate (take antibiotics) for any joint replacements / heart conditions? Please specify.			
Do you have a pacemaker? Or artificial heart valves?			
Pre-Diabetic, Diabetes I or II? Osteoporosis?			
History of cancer? Radiation to head/neck area?			
Are you currently under a physician's care?			
Allergy to any drug?			
Sexually transmitted disease?			
Are your teeth sensitive to: Heat? Cold? Sweets?			
Does food catch between your teeth?			
Do your gums bleed when brushing or floss?			
Difficulty chewing, pain in joint, ear, side of face?			
Have you ever been diagnosed with sleep apnea? If so, are you currently using a sleep device?			
Do you snore?			
Do you wear a night-time appliance?			
Do you have any issues with your wisdom teeth?			
Is there anything you'd like to change about your teeth's appearance?			
Do you smoke?			
Do you have any dental fears?			

(If applicable) How did you find us?_____

(If applicable) Why did you leave your last dentist?_____

Signature of Patient, Parent or Guardian: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my(or patient's) health.It is my responsibility to inform the dental office of any changes in medical status.