HORIZON
DENTAL GROUP
DR. SARAH ENRIGHT & ASSOCIATES

Is there something specific you would like us to address today?

Question			
Do you take any medications? Please list.	❑ **No**	If yes	
Do you pre-medicate? Please list why.	❑ **No**	If yes	
Do you have any health conditions?	❑ **No**	If yes	
Pre-Diabetic, Diabetes I or II?	❑ **No**	If yes	
Osteoporosis?	❑ **No**	If yes	
Cancer?	❑ **No**	If yes	
Radiation to head/neck area?	❑ **No**	If yes	
Are you currently under a physician's care?	❑ **No**	If yes	
Allergy to any drug, please list?	❑ **No**	If yes	
Sexually transmitted disease?	❑ **No**	If yes	
Artificial heart valves?	❑ **No**	If yes	
Are your teeth sensitive to: heat? Cold? Sweets?	❑ **No**	If yes	
Does food catch between your teeth?	❑ **No**	If yes	
Do your gums bleed when brushing?	❑ **No**	If yes	
Difficulty chewing, pain in joint, ear, side of face?	❑ **No**	If yes	
Have you ever been diagnosed with sleep Apnea?	❑ **No**	If yes	
Are you currently using a sleep appliance?	❑ **No**	If yes	
Do you snore?	❑ **No**	If yes	
Do you have any issues with your wisdom teeth?	❑ **No**	If yes	
Are you unhappy with your teeth's appearance?	❑ **No**	If yes	
Do you smoke?	❑ **No**	If yes	
Do you have any dental fears?	❑ **No**	If yes	

How did you find us? ______________________

Why did you leave your last dentist? ______________________

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.

Signature of Patient, Parent or Gurdian: ______________________

Today's Date