

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

- Are you under medical treatment now? Yes ____ No ____ If yes, please explain _____
- Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes ____ No ____
If yes, please explain _____
- Are you currently taking any medication(s) including non-prescription medicine? Yes ____ No ____
If yes, please list all of them _____
- Do you use any tobacco products? Yes ____ No ____
- Are you allergic to or have you had any reactions to the following?

Local Anesthetics (ex. Novocain)	Yes ____	No ____
Penicillin or any other antibiotics	Yes ____	No ____
Sulfa Drugs	Yes ____	No ____
Barbiturates	Yes ____	No ____
Sedatives	Yes ____	No ____
Iodine	Yes ____	No ____
Aspirin	Yes ____	No ____
Any Metals (ex. nickel, mercury, etc.)	Yes ____	No ____
Latex Rubber	Yes ____	No ____
Other _____		
- Do you use controlled substances? Yes ____ No ____
- Are you taking any blood thinners? Yes ____ No ____
- Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Yes ____ No ____

Women Only:

- Are you pregnant or do you think you might be?
Yes ____ No ____
- Are you nursing? Yes ____ No ____
- Are you taking oral contraceptives? Yes ____ No ____

Do you have or have you had any of the following?

	Y	N		Y	N		Y	N
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems / Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Previous Dentist _____ Location/Phone Number _____

- Do your gums bleed while brushing/flossing? Yes No
- Are your teeth sensitive to hot/cold liquids/foods? Yes No
- Are your teeth sensitive to sweet/sour liquids/foods? Yes No
- Do you feel pain in any of your teeth? Yes No
- Do you have any sores or lumps in or near your mouth? Yes No
- Have you had any head, neck or jaw injuries? Yes No
- Have you ever experienced any of the following problems in your jaw?
Clicking Yes No
Pain/Difficulty in opening or closing your mouth? Yes No
- Do you have frequent headaches? Yes No
- Do you clench or grind your teeth? Yes No
- Do you bite your lips or cheeks frequently? Yes No
- Have you had any difficult extractions in the past? Yes No
- Any prolonged bleeding following extractions? Yes No
- Have you had any orthodontic treatment? Yes No
- Do you wear dentures or partials? Yes No
If yes, date of placement _____
- Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No
- Do you like your smile? Yes No

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentists or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent. I understand an 18% interest charge may be applied to my account for balances over 90 days.

Signature of Patient (parent/guardian if minor) _____