Patient Medical History

Physician_____Office Phone_____Date of Last Exam_____

Yes No

1. Are you under medical treatment now?
2. Have you ever been hospitalized for any surgical Operation or serious illness within the last 5 yrs?
   If yes please explain?_____
   _____
3. Are you taking any medication(s) including nonprescription medicine?
   If yes, what medication(s) are you taking?_____
   _____
   _____
4. Have you ever taken Fen-Phen/Redux?
5. Do you use tobacco?
6. Do you use controlled substances?
7. Are you wearing contact lenses?

9. Are you allergic to or have had any reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocain)		
Penicillin or any other Antibiotics		
Sulfa Drugs		
Barbiturates		
Sedatives		
Iodine		
Aspirin		
Any Metals (e.g. Nickel, mercury, etc.)		
Latex Rubber		
Other (please list)		

10. Do you have a persistent cough or throat clearing not associated with a known i illness(lasting more than 3 weeks)?
11. Women Only:
    a) Are you pregnant or think you may be?
    b) Are you nursing?
    c) Are you taking oral contraceptives?

8. Please circle all that apply:

High Blood Pressure	Heart Disease	Chest Pains
Heart Attack	Cardiac Pacemaker	Easily Winded
Rheumatic Fever	Heart Murmur	Stroke
Swollen Ankles	Angina	Hay Fever/ Allergies
Fainting/Seizures	Frequently Tired	Tuberculosis
Asthma	Anemia	Radiation Therapy
Low Blood Pressure	Emphysema	Glaucoma
Epilepsy/Convulsions	Cancer	Recent Weight Loss
Leukemia	Arthritis	Liver Disease
Diabetes	Joint Replacement or Implant	Heart Trouble
Kidney Diseases	Hepatitis/Jaundice	Respiratory Problems
AIDS/HIV Infection	Sexually Transmitted Disease	Mitral Valve Prolapse
Thyroid Problem	Stomach Troubles/Ulcers	Other

Patient Dental History

Name of Previous Dentist and Location_____Date of Last Exam_____

Yes No

1. Do your gums bleed while brushing or flossing?
2. Are your teeth sensitive to hot or cold liquids/food?
3. Are your teeth sensitive to sweet or sour liquids/foods?
4. Do you feel pain to any of your teeth?
5. Do you have any sores or lumps in or near your mouth?
6. Have you ever had any head, neck or jaw injuries?
7. Have you ever experienced any of the following problems in your jaw?
   Clicking
   Pain (joint, ear side of face)
   Difficulty in opening or closing
   Difficulty in chewing

Yes No

8. Do you have frequent headaches?
9. Do you clench or grind our teeth
10. Do you bite your lips or cheeks frequently?
11. Have you ever had difficult extraction s in the past?
12. Have you had any orthodontic treatment?
13. Have you had any prolonged bleeding following extractions?
14. Do you wear dentures or partials?
    If yes, date o f placement?_____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?
16. Do you like your smile?

Authorization and 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 dentist 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 dependents.

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Signature of patient (or parent/guardian if minor) Date