## *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?
8. Do you have or have you had any of the following:

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?

| Yes No | | Yes No | | Yes No |
|---|---|---|---|---|
| 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.

________________________________________________________________________

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