



Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

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|--|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| 1. Are you under medical treatment now?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 9. Are you allergic to or have you had any reactions to the following? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Local Anesthetics (e.g. Novocain)..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, please explain _____ | | | Penicillin or any other Antibiotics | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Sulfa Drugs | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, what medication(s) are you taking? _____ | | | Barbiturates | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Have you ever taken Fen-Phen/Redux?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Sedatives | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Do you use tobacco?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Iodine | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Do you use controlled substances?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Aspirin | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Are you wearing contact lenses?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any Metals (e.g. nickel, mercury, etc.)..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. Do you have or have you had any of the following? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Latex Rubber..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| High Blood Pressure | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Other (please list)..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart Attack | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Rheumatic Fever | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 11. Women Only: | | |
| Swollen Ankles | Yes <input type="checkbox"/> | No <input type="checkbox"/> | a) Are you pregnant or think you may be pregnant?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Fainting / Seizures | Yes <input type="checkbox"/> | No <input type="checkbox"/> | b) Are you nursing?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Asthma | Yes <input type="checkbox"/> | No <input type="checkbox"/> | c) Are you taking oral contraceptives?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Low Blood Pressure | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Chest Pains | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Epilepsy / Convulsions | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Easily Winded | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Leukemia | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Stroke | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Hay Fever / Allergies | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Kidney Diseases | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Tuberculosis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| AIDS or HIV Infection | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Radiation Therapy | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Thyroid Problem | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Glaucoma | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | | | Recent Weight Loss | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | | | Liver Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | | | Heart Trouble | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | | | Respiratory Problems..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | | | Mitral Valve Prolapse..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | | | Other | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

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|---|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| 1. Do your gums bleed while brushing or flossing?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 8. Do you have frequent headaches? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 9. Do you clench or grind your teeth? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 13. Have you had any orthodontic treatment?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? | | | 14. Do you wear dentures or partials?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Clicking | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If yes, date of placement _____ | | |
| Pain (joint, ear, side of face) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Difficulty in opening or closing | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 16. Do you like your smile?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Difficulty in chewing | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | |

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved.
 This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.
 I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X

Signature of patient (or parent/guardian) _____

Date _____