

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

Yes No Yes No

1. Are you under medical treatment now? ☐ ☐ 10. Are you wearing contact lenses? ☐ ☐

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ☐ ☐ 11. Are you allergic to or have you had any reactions to the following?
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 _____ ☐ ☐

3. Are you taking any medication(s) including non-prescription medicine? ☐ ☐ 12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ ☐

If yes, what medication(s) are you taking? _____

4. Have you ever taken Fen-Phen/Redux? ☐ ☐ 13. Women Only: ☐ ☐
Are you pregnant or think you may be pregnant? ☐ ☐
Are you nursing? ☐ ☐
Are you taking oral contraceptives? ☐ ☐

5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? ☐ ☐

6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? ☐ ☐

7. Do you use tobacco? ☐ ☐

8. Do you use controlled substances? ☐ ☐

9. Do you have or have you had any of the following? Yes No Yes No Yes No

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

Patient Dental History

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

Yes No Yes No

1. Do your gums bleed while brushing or flossing? ☐ ☐ 8. Do you have frequent headaches? ☐ ☐

2. Are your teeth sensitive to hot or cold liquids/foods? ☐ ☐ 9. Do you clench or grind your teeth? ☐ ☐

3. Are your teeth sensitive to sweet or sour liquids/foods? ☐ ☐ 10. Do you bite your lips or cheeks frequently? ☐ ☐

4. Do you feel pain to any of your teeth? ☐ ☐ 11. Have you ever had any difficult extractions in the past? ☐ ☐

5. Do you have any sores or lumps in or near your mouth? ☐ ☐ 12. Have you ever had any prolonged bleeding following extractions? ☐ ☐

6. Have you had any head, neck or jaw injuries? ☐ ☐ 13. Have you had any orthodontic treatment? ☐ ☐

7. Have you ever experienced any of the following problems in your jaw? ☐ ☐ 14. Do you wear dentures or partials? ☐ ☐
Clicking ☐ ☐ If yes, date of placement _____
Pain (joint, ear, side of face) ☐ ☐ 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ☐ ☐
Difficulty in opening or closing ☐ ☐ 16. Do you like your smile? ☐ ☐
Difficulty in chewing ☐ ☐

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.

X
Signature of patient (or parent/guardian if minor) _____

Doctor's Comments _____

Signature _____ Date _____