1. Are you having pain or discomfort at this time? ___Yes___No Where?______________________

2. Do you feel nervous about having dental treatment? ___Yes___No

3. Have you ever had a bad experience in a dental office? ___Yes___No ____________________________

4. Have you been hospitalized in the past two years? ___Yes___No Reason?____________________

5. Have you been under the care of a medical doctor during the past two years? ___Yes___No Reason?______________________

6. Have you ever had Periodontal (Gum) Treatment? ___Yes___No When? ______________________

7. What are some questions about dentistry and oral health that you have never had adequately answered for you?

____

Physician's Name _________________________________ Physician's Phone _________________________________

8. Have you taken any medications or drugs during the past two years? ___Yes___No Please List Below:

____ ____

____ ____

____ ____

9. Are you now taking any vitamins, supplements, or herbal therapy? ___Yes___No List __________________________________

10. Are you aware of being allergic to any of the following?

__ Penicillin __Erythromycin __Tetracycline __Sulfa __Keflex __Benzocaine __Topical Anesthetic __Aspirin __Local Anesthetic __Latex

11. Are you aware of being allergic to any **other** medication or substance? ___Yes___No If yes, list ___________________________

12. Mark **"Y" for yes** and **"N" for no** for the following which you have had, or have at present:

__High Blood Pressure	**__Rheumatic Fever**	**__Radiation Therapy**	**__Cancer**	**__Cosmetic Surgery**
__Low Blood Pressure	**__Artificial Joints**	**__Chemotherapy**	**__if yes, what type________**	**__Pain in Jaw Joints**
__Angina Pectoris	**__Diabetes**	**__Blood Transfusion**	**__Tuberculosis**	**__Thyroid Condition**
__Mitral Valve Prolapse	**__Anemia**	**__Seizures**	**__Emphysema/ COPD**	**__Nervousness**
__Heart Murmur	**__Hepatitis B or C**	**__Drug Addiction**	**__HIV Positive**	**__Psychiatric Tx**
__Heart Attack	**__Hepatitis A**	**__Fainting / Dizziness**	**__Leukemia**	**__Cortisone Medicine**
__Heart Pacemaker	**__Liver Disease**	**__Ulcers**	**__AIDS**	**__Allergies/Hives/Hay fever**
__Stroke	**__Yellow Jaundice**	**__Glaucoma**	**__Prolonged Cough**	**__ Hemophilia**
__ Heart Disease	**__Arthritis**	**__Cold Sores**	**__Head or Neck Trauma**	**__Asthma**

13. Do you ever have shortness of breath or chest pains? ___Yes___No ______________________________

14. Do you have any **prosthetic heart valves**, **pins, plates, screws etc.?** ___Yes___No List____________________________

15. Have you ever had a **total joint replacement**? ___Yes___No How/why ______________________

16. Do your ankles swell during the day? ___Yes___No

17. Have you ever been treated with Bisphosphonates? ___Yes___No Fosamax, Aredia, Zometa, other?_______

18. Do you smoke? ___Yes___No How long______ Packs/Day________

19. Has your medical doctor ever said you have a **cancer or tumor**? ___Yes___No Type?____________________________

20. Do you have any **disease, condition, or problem not listed**? ___Yes___No What?____________________________

21. **Women only** Are you pregnant or think you may be? ___Yes___No

22. **Women only** Are you taking birth control pills? ___Yes___No

Consent: *The undersigned hereby authorizes the doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (name of patient)___________________________________ and further authorize consent that the doctor choose and employ such assistance as s/he deems fit.* ***I also understand the responsibility for payment for dental services provided in this office, for my dependents or myself, is mine and is due and payable at the time services are rendered.*** *In the event of default, I(we) promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees, as my be required, to effect collection of this note. If insurance is filed by this office it is done as a courtesy. I also understand that a* **Full Mouth Series of Radiographs is required by this office every 3-5 years, as well as annual Periodic Exams, in order to be a patient of record.**

*Signed by patient or parent/guardian*____*Date*___________________