Dental History

Most Recent Cleaning:______________ Are you experiencing any dental problems?_______________

Any previous major dental treatment? O yes O No Please Describe:___________________________

How often do you brush? ________ Electric/Manual toothbrush?___________ Floss? ________

Additional Aids? ____________________________

Have you ever had any of the following conditions?

Yes	No		Yes	No		Yes	No	
O	O	Bleeding Gums	O	O	Tierd Jaw	O	O	Endodontic Treatment (Root Canal)
O	O	Tender Swollen Gums	O	O	Clenching Teeth	O	O	Complicated Extraction
O	O	Loose Teeth	O	O	Burning Tongue	O	O	Crown (Cap) or Bridge
O	O	Sensitive Teeth	O	O	Sinus Conditions	O	O	Dental Implants
O	O	Mouth Sores	O	O	Fear of Dentistry	O	O	Removable Dentures (full or partial)
O	O	Pain in Mouth	O	O	Orthodontic Treatment (Braces)	O	O	Oral Habits ______________
O	O	Ear Ache	O	O	Periodontal Treatment (Gums)	O	O	Other ________________

Medical History

Physician: ________________________ Physician Phone: _________________ Date of Last Exam:________

1. Are you under medical treatment now? O Yes O No
   What Condition(s)? ________________________
   ____

2. Are you taking any medications including non-prescription drugs? O Yes O No
   If yes, please list: ________________________
   ____
   ____
   ____
   ____
   ____
   ____
   ____

3. Have you ever been hospitalized for any surgical operat serious illness? O Yes O No
   Please explain: ________________________
   ____
   ____

4. Do you use tobacco? O Yes O No
   How much/often do you smoke? ________________

5. Do you use alcohol or drugs? O Yes O No

6. Are you allergic to or have you ever had any reactions to the following:
   - Local anesthetics (e.g. Novocain)…... .O Yes O No
   - Penicillin or other Antibiotics……….. O Yes O No
   - Sulfa Drugs…………………………. O Yes O No
   - Barbiturates…………………………. O Yes O No
   - Sedatives……………………………. O Yes O No
   - Aspirin………………………………. O Yes O No
   - Latex…………………………………. O Yes O No
   - Other…………………………………. O Yes O No

7. Women Only:
   A. Are you or do you think you may be pregnant O Yes O No
   B. Are you nursing? O Yes O No

8. Do you need to take any premedication prior to dental work?
   O Yes O No

9. DO YOU HAVE ANY OF THE FOLLOWING?

Yes No		Yes No		Yes No		Yes No	
O O	High Blood Pressure	O O	Kidney Disease	O O	Cancer	O O	Tuberculosis
O O	Heart Attack	O O	Aids or HIV	O O	Arthritis	O O	Radiation Therapy
O O	Rheumatic Fever	O O	Thyroid	O O	Biophosphonate Meds (current or previous) (i.e. fosamax,actonel)	O O	Glaucoma
O O	Swollen Ankles	O O	Heart Disease			O O	Liver Disease
O O	Recent Weight Loss	O O	Cardiac Pacemaker			O O	Heart Trouble
O O	Fainting/Seizures	O O	Heart Murmur	O O	Joint Replacement	O O	Hepatitis/Jaundice
O O	Asthma	O O	Angina	O O	STD	O O	Stroke
O O	Low Blood Pressure	O O	Frequently Tired	O O	Hay Fever/Allergies	O O	Headaches
O O	Epilepsy/Convulsions	O O	Anemia	O O	Stomach Trouble/Ulcers	O O	Anxiety
O O	Leukemia	O O	Emphysema	O O	Chest Pains	O O	Other
O O	Diabetes	O O	Respiratory Problems	O O	Easily winded		

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 my child or me during the period of such Dental care to third party payers 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 or my dependent's behalf. I consent to credit check should one be necessary.

X____