PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
Are you under medical treatment now? If so, what for _____	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness in the last 5 years? If yes, please list _____	☐	☐
Are you taking any medication(s), including any non-prescription medicine? If yes, what medication(s) _____	☐	☐
Have you ever taken Phen-Fen/Redux?	☐	☐
Do you use tobacco?	☐	☐
Are you on a special diet?	☐	☐

Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Acrylic	☐	☐
Codeine	☐	☐
Other (please list) _____	☐	☐

For Women: Are you taking oral contraceptives? ☐ Yes ☐ No
Are you pregnant or think you may be pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Do you have or have you had any of the following?

	Yes	No	N/A		Yes	No	N/A		Yes	No	N/A		Yes	No	N/A
AIDS/HIV Positive	☐	☐	☐	Congenital Heart Disorder	☐	☐	☐	Heart Pacemaker	☐	☐	☐	Renal Dialysis	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	Diabetes	☐	☐	☐	Heart Trouble/Disease	☐	☐	☐	Rheumatic Fever	☐	☐	☐
Anemia	☐	☐	☐	Drug Addiction	☐	☐	☐	Hemophilia	☐	☐	☐	Rheumatism	☐	☐	☐
Angina	☐	☐	☐	Easily Winded	☐	☐	☐	Hepatitis A	☐	☐	☐	Scarlet Fever	☐	☐	☐
Arthritis/Gout	☐	☐	☐	Emphysema	☐	☐	☐	Hepatitis B or C	☐	☐	☐	STD	☐	☐	☐
Artificial Heart Valve	☐	☐	☐	Epilepsy or Seizures	☐	☐	☐	High Blood Pressure	☐	☐	☐	Shingles	☐	☐	☐
Artificial Joint	☐	☐	☐	Excessive Bleeding	☐	☐	☐	High Cholesterol	☐	☐	☐	Sickle Cell Disease	☐	☐	☐
Asthma	☐	☐	☐	Excessive Thirst	☐	☐	☐	Hypoglycemia	☐	☐	☐	Sinus Trouble	☐	☐	☐
Blood Disease	☐	☐	☐	Fainting Spells/Dizziness	☐	☐	☐	Kidney Problems	☐	☐	☐	Stroke	☐	☐	☐
Breathing Problems	☐	☐	☐	Frequent Cough	☐	☐	☐	Liver Disease	☐	☐	☐	Swelling of Limbs	☐	☐	☐
Bruise Easily	☐	☐	☐	Glaucoma	☐	☐	☐	Low Blood Pressure	☐	☐	☐	Thyroid Disease	☐	☐	☐
Cancer	☐	☐	☐	Hay Fever	☐	☐	☐	Osteoporosis	☐	☐	☐	Tuberculosis	☐	☐	☐
Chemotherapy	☐	☐	☐	Heart Attack/Failure	☐	☐	☐	Psychiatric Care	☐	☐	☐	Tumors/Growths	☐	☐	☐
Chest Pains	☐	☐	☐	Heart Murmur	☐	☐	☐	Radiation Treatment	☐	☐	☐	Ulcers	☐	☐	☐
												Yellow Jaundice	☐	☐	☐

Have you ever had any serious illness not listed? ☐ Yes ☐ No If yes _____

PATIENT DENTAL HISTORY

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

	Yes	No	N/A
Do your gums bleed while brushing or flossing?	☐	☐	☐
Are your teeth sensitive to hot/cold liquids/foods?	☐	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐	☐
Do you feel pain to any of your teeth?	☐	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐	☐
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	N/A
Do you have frequent headaches?	☐	☐	☐
Do you clench or grind your teeth?	☐	☐	☐
Do you bite your lips, cheeks or nails frequently?	☐	☐	☐
Do you take Fluoride supplements	☐	☐	☐
Have you ever had any difficult extractions?	☐	☐	☐
Have you ever had prolonged bleeding following extractions?	☐	☐	☐
Have you had any orthodontic treatment (braces)?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
If yes, date of placement _____			
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐	☐
Do you like your smile?	☐	☐	☐

Other comments for the Doctor _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health, and my child's health. It is my responsibility to inform the dental office of any changes in mine & my child's medical status. I also authorize the dental staff to perform the necessary dental services myself, or my child may need. I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to myself, or my child, during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my 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_____ Date _____
Signature of patient (or parent if minor)

X_____ Date _____
Signature of Dentist