Patient Medical History

Name of Physician _____ Office Phone _____ Date of last exam_____

Height _____ Current Weight _____

	Yes	No
1. Are you under medical treatment now?	____	____
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____ _____	____	____
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) _____ _____	____	____
4. Have you ever been diagnosed with or treated for osteoporosis (e.g. Fosamax)	____	____
5. Do you use any alcohol products?	____	____
6. Do you use tobacco? If yes, Dip or Smoke?	____	____
7. Do you use controlled substances?	____	____
8. Are you wearing contact lenses?	____	____

9. Are you allergic to or have you had any reactions to the following?	Yes	No
Local anesthetic (e.g. Novocain)	____	____
Penicillin or other antibiotic	____	____
Sulfa Drugs	____	____
Barbiturates, sedatives or sleeping pills	____	____
Iodine	____	____
Aspirin	____	____
Codeine or other narcotics	____	____
Any metals (e.g. nickel, mercury, ect.)	____	____
Latex rubber	____	____
Other _____	____	____
10. Do you or have you ever been required to take antibiotics before dental treatment?	____	____
Women Only:		
Are you pregnant or think you may be?	____	____
Are you nursing?	____	____
Are you taking oral contraceptives?	____	____

Do you have/had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	____	____	Heart Disease	____	____	Chest Pain	____	____
Heart Attack	____	____	Cardiac Pacemaker	____	____	Easily Winded	____	____
Rheumatic/Scarlet Fever	____	____	Heart Murmur	____	____	Stroke	____	____
Swollen Ankles	____	____	Angina	____	____	Hay Fever/Allergies	____	____
Fainting/Seizures	____	____	Frequently Tired	____	____	Tuberculosis	____	____
Asthma	____	____	Anemia	____	____	Radiation Therapy	____	____
Low Blood Pressure	____	____	Emphysema	____	____	Glaucoma	____	____
Epilepsy/Convulsions	____	____	Cancer	____	____	Recent Weight Loss	____	____
Leukemia	____	____	Arthritis	____	____	Liver Disease	____	____
Diabetes	____	____	Joint Replacement/Implant	____	____	Metal Plates	____	____
Kidney Disease	____	____	Hepatitis/Jaundice (please circle)	____	____	Respiratory Problems	____	____
AIDS or HIV Infection	____	____	Sexually Transmitted Disease	____	____	Mitral Valve Prolapse	____	____
Thyroid Problems	____	____	Stomach Troubles/Ulcer	____	____	Other _____	____	____

Patient Dental History

Name of previous Dentist and location _____

Date of last Exam _____ Date of last Cleaning _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	___	___
2. Are your teeth sensitive to hot/cold or liquid/food?	___	___
3. Are your teeth sensitive to sweet/sour?	___	___
4. Do you feel pain to any of your teeth?	___	___
5. Do you have any sores or lumps in or near your mouth?	___	___
6. Have you had any head, neck, or jaw injuries?	___	___
7. Have you ever experienced any of the following Problems in your jaw?		
Clicking	___	___
Pain (joint, ear, side of face)	___	___
Difficulty opening or closing	___	___
Difficulty in chewing	___	___

	Yes	No
8. Do you have frequent headaches?	___	___
9. Do you clench or grind your teeth?	___	___
10. Do you bite your lips or cheeks?	___	___
11. Have you had any difficult extractions in the past?	___	___
12. Have you had any prolonged bleeding in the past?	___	___
13. Have you had orthodontic treatment?	___	___
14. Do you wear dentures or partials? If yes, date of placement _____	___	___
15. Have you ever received oral hygiene instructions regarding your teeth?	___	___
16. Do you like your smile?	___	___

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 diagnoses 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 of service. 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) ***Date***