Patient Name______________________________

Medical History

Physician_____________________________Office Phone______________Date of last exam ____________

◆ Are you under medical treatment at this time? What for?_______________________________________

◆ Have you been hospitalized for any surgery or serious illness in the last 5 years? Please Explain

____

◆ Are you taking any medications including non-prescription medications? List

____

◆ Are you allergic to or had any reaction to the following?(Please circle)

◆ Local Anesthetics (Novocaine, Lidocaine)

◆ Penicillin or other Antibiotics ◆ Sedatives ◆ Aspirin

◆ Any Metals (Nickel) ◆ Other (please describe)

◆ Women only ◆

◆ Are you pregnant ◆ Are you nursing?

◆ Are you taking birth control?

◆ Do you have any of the following?

Learning disability	Y N	Fainting/seizures	Y N	Anemia	Y N
Describe______________		Difficulty breathing	Y N	Leukemia	Y N
Emotional problems	Y N	Asthma or Emphysema	Y N	Cancer	Y N
Describe______________		Lung problems	Y N	Describe______________	
Psychological problems	Y N	Easily Winded	Y N	Chemo Therapy	Y N
Describe______________		Diabetes	Y N	Radiation Therapy	Y N
Heart disease/heart attack	Y N	Last A1C value__________		Joint replacement	Y N
Other heart problems	Y N	Kidney Disease	Y N	Date and what joint________	
Cardiac pacemaker	Y N	Liver Disease	Y N	Stomach troubles/ulcers	Y N
Angina/Chest pains	Y N	AIDS or HIV	Y N	Hay Fever /Allergies	Y N
Stroke	Y N	Hepatitis	Y N	Tuberculosis	Y N
High blood pressure	Y N	Thyroid Problem	Y N	Sleep apnea	Y N
Low blood pressure	Y N	Frequently tired	Y N	Tobacco use	Y N

Dental History

Name of Previous Dentist ____________________Location______________________Date of Last Visit________

Do your gums bleed while brushing or flossing?	Y N	Do you clench or grind your teeth?	Y N
Are you teeth sensitive to hot/cold/sweet?	Y N	Do you bite your lips/cheeks frequently?	Y N
Do you have pain in any teeth?	Y N	Have you ever had a difficult extractions?	Y N
Do you have any sores or lumps in your mouth	Y N?	Have you ever had any prolonged bleeding following extractions?	Y N
Have you had any head neck or jaw injuries?	Y N	Have you had any orthodontic treatment?	Y N
Have you ever had any of the following problems with your jaw?		Do you where dentures or partials?	Y N
Clicking		Date of placement ______________	
Pain (joint, eat, or side of face)			
Difficulty in opening or closing		Do you like your smile?	Y N
Difficulty in chewing		Are you interested in tooth whitening?	Y N
Do you have frequent headache?	Y N	Are you interested in straighter teeth?	Y N

Authorization and Release

I certify that I have read and understand the above information and have answered the questions to the best of my knowledge. 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 render to me or my child to third party payors (insurance companies) and/or health practitioners. I authorize my insurance company to pay directly to the dentist 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 dependants.

X____Date:________________

Signature of Patient (or parent/guardian if minor)