Patient Medical History

Physician_____Office Phone_____

Date of Last Exam_____

1. Are you under medical treatment right now? Y / N
2. Have you been hospitalized for any surgical operations or serious illness within the last 5 years? Y / N

If yes, please explain _____

3. Are you taking any medication(s) including non-prescription medicine? Y / N

If yes, what medication(s) are you taking?

_____

4. Have you ever taken Phen-Fen/Redux? Y / N
5. Do you use tobacco? Y / N
6. Do you use controlled substances? Y / N
7. Are you wearing contact lenses? Y / N

9. Are you allergic to or have you had any reactions to the following?

Local Anesthetics (e.g. Novocain)	Y / N
Penicillin or other Antibiotics	Y / N
Sulfa Drugs	Y / N
Barbiturates	Y / N
Sedatives	Y / N
Iodine	Y / N
Aspirin	Y / N
Any Metals (e.g.nickel, mercury, etc.)	Y / N
Latex Rubber	Y / N
Other (please list)_____	

10. WOMEN ONLY:

Are you taking oral contraceptives?	Y / N
Are you pregnant or think you may be pregnant?	Y / N
Are you nursing?	Y / N

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

High Blood Pressure ..... Y / N	Heart Disease ..... Y / N	Chest Pains ..... Y / N
Heart Attack ..... Y / N	Cardiac Pacemaker ..... Y / N	Easily Winded ..... Y / N
Rheumatic Fever ..... Y / N	Heart Murmur ..... Y / N	Stroke ..... Y / N
Swollen Ankles ..... Y / N	Angina ..... Y / N	Hay Fever/Allergies ..... Y / N
Fainting/Seizures ..... Y / N	Frequently Tired ..... Y / N	Tuberculosis ..... Y / N
Asthma ..... Y / N	Anemia ..... Y / N	Radiation Therapy ..... Y / N
Low Blood Pressure ..... Y / N	Emphysema ..... Y / N	Glaucoma ..... Y / N
Epilepsy/Convulsions ..... Y / N	Cancer ..... Y / N	Recent Weight Loss ..... Y / N
Leukemia ..... Y / N	Arthritis ..... Y / N	Liver Disease ..... Y / N
Diabetes ..... Y / N	Joint Replacement/Implant ..... Y / N	Heart Trouble ..... Y / N
Kidney Diseases ..... Y / N	Hepatitis/Jaundice ..... Y / N	Respiratory Problems ..... Y / N
AIDS or HIV Infection ..... Y / N	Sexually Transmitted Disease ..... Y / N	Mitral Valve Prolapse ..... Y / N
Thyroid Problem ..... Y / N	Stomach Troubles/Ulcers ..... Y / N	
Other ..... Y / N		

Patient Dental History

Name of Previous Dentist/Location_____

Date of Last Exam _____

1. Do your gums bleed while brushing or flossing? Y / N
2. Are your teeth sensitive to hot or cold liquids/foods? Y / N
3. Are your teeth sensitive to sweet or sour liquids/foods? Y / N
4. Do you feel any pain in your teeth? Y / N
5. Do you have any sores or lumps in or near your mouth? Y / N
6. Have you had any head, neck, or jaw injuries? Y / N
7. Have you ever experienced any of the following:
   - Problems in your jaw? Y / N
   - Clicking? Y / N
   - Pain (joint, ear, side of face)? Y / N
   - Difficulty in opening or closing? Y / N
   - Difficulty in chewing? Y / N
8. Do you have frequent headaches? Y / N
9. Do you clench or grind your teeth? Y / N
10. Do you bite your lips or cheeks frequently? Y / N
11. Have you ever had any difficult extractions? Y / N
12. Have you ever had any prolonged bleeding following extractions? Y / N
13. Have you had any orthodontic treatment? Y / N
14. Do you wear dentures or partials? Y / N
    If yes, date of placement_____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Y / N
16. Do you like your smile? Y / N

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 diagnosis 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 for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of patient (or parent if patient is a minor)

Doctor's comments

_____

_____

_____

Signature_____ Date_____