**Patient Medical History**

**Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Are you under medical treatment right now?.....................Y / N 9. Are you allergic to or have you had any reactions**

**2. Have you ever been hospitalized for any surgical to the following?**

**operations or serious illness within the last 5 years?........Y / N Local Anesthetics (e.g. Novocain)……………………….Y / N**

**If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Penicillin or other Antibiotics…………………………..Y / N**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sulfa Drugs………………………………………………….Y / N**

**3. Are you taking any medication(s) including Barbiturates………………………………………………….Y / N**

**non-prescription medicine?.................................................Y / N Sedatives……………………………………………………..Y / N**

**If yes, what medication(s) are you taking?\_\_\_\_\_\_\_\_\_\_\_ Iodine…………………………………………………………Y / N**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Aspirin………………………………………………………..Y / N**

**4. Have you ever taken Phen-Fen/Redux?.............................Y / N Any Metals (e.g.nickel, mercury, etc.)…………………Y / N**

**5. Do you use tobacco?............................................................Y / N Latex Rubber………………………………………………..Y / N**

**6. Do you use controlled substances?.....................................Y / N Other (please list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**7. Are you wearing contact lenses?.........................................Y / N 10. WOMEN ONLY:**

**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? Are you taking oral contraceptives?...........................Y / N**

**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 8. Do you have frequent headaches?.......................................Y / N**

**2. Are you teeth sensitive to hot or cold liquids/foods?.............. Y / N 9. Do you clench or grind your teeth?....................................Y / N**

**3. Are you teeth sensitive to sweet or sour liquids/foods?.......... Y / N 10. Do you bite your lips or cheeks frequently?....................Y / N**

**4. Do you feel any pain in your teeth?......................................... Y / N 11. Have you ever had any difficult extractions?...................Y / N**

**5. Do you have any sores or lumps in or near your mouth? ….Y / N 12. Have you ever had any prolonged bleeding**

**6. Have you had any head, neck, or jaw injuries?....................... Y / N following extractions?...............................................................Y / N**

**7. Have you ever experienced any of the following 13. Have you had any orthodontic treatment?.......................Y / N**

**problems in your jaw? 14. Do you wear dentures or partials?....................................Y / N**

**Clicking?.................................................................................... Y / N If yes, date of placement\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pain (joint, ear, side of face)?................................................. Y / N 15. Have you ever received oral hygiene instructions**

**Difficulty in opening or closing?............................................. Y / N regarding the care of your teeth and gums?..........................Y / N**

**Difficulty in chewing?.............................................................. 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 minor)**

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| **Doctor’s comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |