

Patient Medical History

- 1. Are you currently under medical treatment? Yes No
2. Have you ever been hospitalized for any surgical operation or serious illness? Yes No
3. Are you taking any medication(s) including non-prescription medicine? Yes No
If yes, what medications are you taking?

- 4. Do you use tobacco? Yes No
5. Do you use alcohol? Yes No
6. Do you use cocaine or other recreational drugs? Yes No
7. Are you wearing contact lenses? Yes No

- 10. Do you have or have you had any of the following?
High Blood Pressure, Heart Attack, Rheumatic Fever, Swollen Ankles, Fainting/Seizures, Asthma, Low Blood Pressure, Epilepsy/Convulsions, Leukemia, Diabetes, Kidney Diseases, AIDS or HIV Infection, Thyroid Problem, Heart Disease, Cardiac Pacemaker, Heart Murmur, Angina, Frequently Tired, Anemia, Emphysema, Cancer, Arthritis, Joint Replacement or Implant, Hepatitis/Jaundice, Sexually Transmitted Disease, Stomach Troubles/Ulcers

Patient Name

- 8. Are you allergic to or have you had any reactions to the following?
Local Anesthetics (e.g. Novacaine), Penicillin or other Antibiotics, Sulfa Drugs, Barbituates, Sedatives, Iodine, Aspirin, Other
9. Women only:
-Are you pregnant or think you may be pregnant?
-Are you nursing?
-Are you taking birth control pills?

Name of Physician Office Phone Last Exam

Patient Dental History

- 1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to hot or cold liquids or foods? Yes No
3. Are your teeth sensitive to sweet or sour liquids or foods? Yes No
4. Do you feel any pain to any of your teeth? Yes No
5. Do you have any sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck or jaw injuries? Yes No
7. Have you ever experienced any of the following problems with your jaw?
a) Clicking?
b) Pain(joint, ear, side of face)?
c) Difficulty in opening or closing?
d) Difficulty chewing?
8. Do you have frequent headaches? Yes No
9. Do you clench or grind your teeth? Yes No
10. Do you bite your lips or cheeks frequently? Yes No
11. Have you ever had any difficult extractions in the past? Yes No
12. Have you ever had any orthodontic work? Yes No
13. Have you ever had any prolonged bleeding following extractions? Yes No
14. Have you ever had instruction on the correct method of brushing your teeth? Yes No
15. Have you ever had instructions on the care of your gums? Yes No

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

For Office Use Only
UPDATE

Initial Date

Patient Signature Date