

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Are you allergic to or have you had any reactions to the following? | | |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (e.g. Novocaine) | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain _____ | | | Penicillin or any other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) Including non-prescription medicine? | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what medication(s) are you taking? _____ | | | Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever taken Phen-Fen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin or Codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you wearing contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> | Any Metals (e.g. nickel, mercury, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Latex Rubber | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other (Please List) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have or have you had any of the following? | | | 10. Women Only: | | |
| | | | a) Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | b) Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | c) Are you taking oral contraceptives? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No | | Yes | No | | Yes | No |
|------------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever / Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting / Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy / Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement or Implants | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles / Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| | | | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near you mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following Problems in your jaw? | | | 14. Do you wear dentures or partials? | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking | <input type="checkbox"/> | <input type="checkbox"/> | If yes, date the placement _____ | | |
| Pain (joint, ear, side of face) | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you like your smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in chewing | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Authorization and Release

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he/she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his/her staff. I agree to pay for all services rendered by this office. I also authorize my insurance to pay directly to the dentist.

SIGNATURE OF RESPONSIBLE PARTY _____

RELATIONSHIP _____

DATE _____

Doctor's Comments _____

Doctor's Signature _____

Date _____