

Patient Medical History

Patient's Name _____ Physician's Name _____

1. Are you under treatment now? YES NO
For what: _____
2. Have you ever been hospitalized for any surgical operation or serious illness within the last five years? YES NO
If yes, please explain _____
3. Are you taking any medication(s) including non-prescription medicine? YES NO
If yes, what medication (s) are you taking?

4. Do you use tobacco? YES NO
5. Do you use controlled substances? YES NO
6. Are you allergic to or have you had any reactions to the following? YES NO
- Local Anesthetics (eg. xylocaine) YES NO
- Penicillin or any other Antibiotics YES NO
- Sulfa Drugs YES NO
- Barbiturates YES NO
- Sedatives YES NO
- Iodine YES NO
- Asprin YES NO
- Any Metals (e.g. nickel, mercury etc.) YES NO
- Latex Rubber. YES NO
- Other (please list). YES NO
7. Women Only:
- a) Are you pregnant or think you may be pregnant? YES NO
- b) Are you nursing? YES NO
- c) Are you taking oral contraceptives? YES NO
8. Do you have or have you had any of the following?
- | YES | NO | YES | NO | YES | NO | | | | | |
|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Fainting/Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Convulsions | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | AIDS or HIV Infection. | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles/Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement or Implant | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease. | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Type: _____ | | | Other | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Date: _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Dental History

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

1. Do your gums bleed while brushing or flossing? YES NO
2. Are your teeth sensitive to hot or cold liquids/foods? YES NO
3. Are your teeth sensitive to sweets? YES NO
4. Do you feel 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 in your jaw?
- | | | |
|----------------------------------|--------------------------|--------------------------|
| Clicking | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain (joint, ear, side of face) | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in chewing | <input type="checkbox"/> | <input type="checkbox"/> |
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 prolonged bleeding following extractions? YES NO
13. Have you had any orthodontic treatment? YES NO
14. Do you wear dentures or partials? YES NO
If yes, date of placement _____
15. Do you like your smile? 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 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) _____

Date _____