Patient Medical History

Physician:_________________________Office Phone:___________________Date of Last Exam_______________

1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operation or serious illness? Yes No
3. Are you currently taking any medication(s) including non-prescription medicines? Yes No
   If yes, please list____________________
   ____
   ____
4. Do you use tobacco? Yes No
5. Do you use alcohol or other drugs daily? Yes No
6. Are you wearing contact lenses? Yes No
7. Are you allergic to or have you had any reactions to the following?

local anesthetics (e.g., Novocain)	Yes	No
penicillin or other antibiotics	Yes	No
Sulfa drugs	Yes	No
Barbiturates	Yes	No
Sedatives	Yes	No
Iodine	Yes	No
Aspirin	Yes	No
Other ________________	Yes	No

8. Have you ever been told you need antibiotics prior to dental treatment? Yes No
9. Women only:
   a. Are you pregnant? Yes No
   b. Are you nursing ? Yes No
   c. Are you taking birth control pills? Yes No

10. Do you have any of the following?

High blood pressure	Yes	No	Heart Disease	Yes	No	Chest Pains	Yes	No
Heart attack	Yes	No	Cardiac pacemaker	Yes	No	Easily winded	Yes	No
Rheumatic Fever	Yes	No	Heart murmur	Yes	No	Stroke	Yes	No
Swollen ankles	Yes	No	Angina	Yes	No	Hay fever / allergies	Yes	No
Fainting / Seizures	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Asthma	Yes	No	Anemia	Yes	No	Radiation therapy	Yes	No
Low blood pressure	Yes	No	Emphysema	Yes	No	Glaucoma	Yes	No
Epilepsy/Convulsion	Yes	No	Cancer	Yes	No	Drug dependency in the past?	Yes	No
Leukemia	Yes	No	Arthritis	Yes	No	Liver Disease	Yes	No
Diabetes	Yes	No	Joint replacement	Yes	No	Heart trouble	Yes	No
Kidney Disease	Yes	No	Hepatitis or Jaundice	Yes	No	Respiratory Problems	Yes	No
AIDS or HIV infection	Yes	No	Thyroid problem	Yes	No	Stomach troubles / ulcers	Yes	No

Patient Dental History

Last dentist seen: ___________________ Date of last dental visit: ____________
Purpose (was it a routine 6 months visit or emergency in nature):__________________

Bleeding gums while brushing or flossing?	Yes	No
Teeth are sensitive to hot or cold liquids?	Yes	No
Teeth are sensitive to sweet or sour?	Yes	No
Have you had orthodontics in the past?	Yes	No
Have you ever had correct instructions on brushing?	Yes	No
Is bad breath a concern for you?	Yes	No
Do you have frequent headaches?	Yes	No
Do you clench or grind your teeth?	Yes	No
Do you bite your lips or check frequently?	Yes	No
Prolonged bleeding from anything?	Yes	No
Have you ever had correct instructions on flossing?	Yes	No

Authorization and Release

I certify that I have read and understand the above questions and have answered accurately and truthfully. 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 children during the period of such dental care, to third party payers 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 that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or to my dependents.

X____
Signature of patient or parent if minor