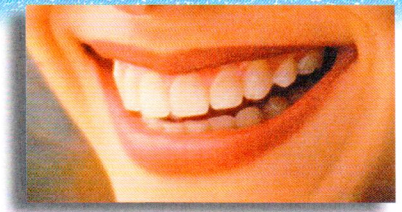


# Patient Medical History



Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Are you under medical treatment now?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	10. Are you wearing contact lenses?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... If yes, please explain _____	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you allergic to or have you had any reactions to the following?		
3. Are you taking any medication(s) including non-prescription medicine?..... If yes, what medication(s) are you taking? _____	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (e.g. Novocain).....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fen-Phen/Redux?.....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?.....	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?.....	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you use tobacco?.....	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you use controlled substances?.....	<input type="checkbox"/>	<input type="checkbox"/>	Iodine.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have or have you had any of the following?			Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Latex Rubber.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....		
Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	13. Women Only:		
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	a) Are you pregnant or think you may be pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	b) Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	c) Are you taking oral contraceptives?.....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequently Tired.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>			
Joint Replacement or Implant.....	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis / Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>			
Sexually Transmitted Disease.....	<input type="checkbox"/>	<input type="checkbox"/>			
Stomach Troubles / Ulcers.....	<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 <input type="checkbox"/>	No <input type="checkbox"/>	8. Do you have frequent headaches?.....	Yes <input type="checkbox"/>	No <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 your 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?..... If yes, date of placement _____	<input type="checkbox"/>	<input type="checkbox"/>
Clicking.....	<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"/>
Pain (joint, ear, side of face).....	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile?.....	<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"/>			

# Authorization and Release

**Payment is due in full at the time of treatment unless prior arrangements have been approved.**  
 This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.  
 I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

**X** \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of patient (or parent/guardian if minor)