

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you under medical treatment now? | ☐ | ☐ | 10. Are you wearing contact lenses? | ☐ | ☐ |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? | ☐ | ☐ | 11. Are you allergic to or have you had any reactions to the following? | | |
| If yes, please explain _____ | | | Local Anesthetics (e.g. Novocain) | ☐ | ☐ |
| | | | Penicillin or any other Antibiotics | ☐ | ☐ |
| 3. Are you taking any medication(s) including non-prescription medicine? | ☐ | ☐ | Sulfa Drugs | ☐ | ☐ |
| If yes, what medication(s) are you taking? _____ | | | Barbiturates | ☐ | ☐ |
| | | | Sedatives | ☐ | ☐ |
| 4. Have you ever taken Fen-Phen/Redux? | ☐ | ☐ | Iodine | ☐ | ☐ |
| 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? | ☐ | ☐ | Aspirin | ☐ | ☐ |
| 6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? | ☐ | ☐ | Any Metals (e.g. nickel, mercury, etc.) | ☐ | ☐ |
| 7. Do you use tobacco? | ☐ | ☐ | Latex Rubber | ☐ | ☐ |
| 8. Do you use controlled substances? | ☐ | ☐ | Other (please list) _____ | | |
| 9. Do you have or have you had any of the following? | | | 12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | ☐ | ☐ |

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

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? | ☐ | ☐ | 8. Do you have frequent headaches? | ☐ | ☐ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ☐ | ☐ | 9. Do you clench or grind your teeth? | ☐ | ☐ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ☐ | ☐ | 10. Do you bite your lips or cheeks frequently? | ☐ | ☐ |
| 4. Do you feel pain to any of your teeth? | ☐ | ☐ | 11. Have you ever had any difficult extractions in the past? | ☐ | ☐ |
| 5. Do you have any sores or lumps in or near your mouth? | ☐ | ☐ | 12. Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| 6. Have you had any head, neck or jaw injuries? | ☐ | ☐ | 13. Have you had any orthodontic treatment? | ☐ | ☐ |
| 7. Have you ever experienced any of the following problems in your jaw? | | | 14. Do you wear dentures or partials? | ☐ | ☐ |
| Clicking | ☐ | ☐ | If yes, date of placement _____ | | |
| Pain (joint, ear, side of face) | ☐ | ☐ | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | ☐ | ☐ |
| Difficulty in opening or closing | ☐ | ☐ | 16. Do you like your smile? | ☐ | ☐ |
| Difficulty in chewing | ☐ | ☐ | | | |

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.

X

Signature of patient (or parent/guardian if minor) _____

Date _____

Doctor's Comments _____

Signature _____

Date _____