NAME _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____		
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
6. ARE YOU WEARING CONTACT LENSES?	☐	☐

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY.

_____

_____

8. WHEN WAS YOUR LAST COMPLETE PHYSICAL? _____

9. WOMEN ONLY:	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

☐ HIGH BLOOD PRESSURE	☐ HEART DISEASE	☐ CHEST PAINS	☐ KIDNEY DISEASES
☐ HEART ATTACK	☐ CARDIAC PACEMAKER	☐ EASILY WINDED	☐ AIDS OR HIV INFECTION
☐ RHEUMATIC FEVER	☐ HEART MURMUR	☐ STROKE	☐ THYROID PROBLEM
☐ SWOLLEN ANKLES	☐ ANGINA	☐ HAY FEVER / ALLERGIES	☐ HEPATITIS / JAUNDICE
☐ FAINTING / SEIZURES	☐ FREQUENTLY TIRED	☐ TUBERCULOSIS	☐ SEXUALLY TRANSMITTED DISEASE
☐ ASTHMA	☐ ANEMIA	☐ RADIATION THERAPY	☐ STOMACH TROUBLES / ULCERS
☐ LOW BLOOD PRESSURE	☐ EMPHYSEMA	☐ GLAUCOMA	☐ RESPIRATORY PROBLEMS
☐ EPILEPSY / CONVULSIONS	☐ CANCER	☐ RECENT WEIGHT LOSS	☐ OTHER _____
☐ LEUKEMIA	☐ ARTHRITIS	☐ LIVER DISEASE	_____
☐ DIABETES	☐ JOINT REPLACEMENT OR IMPLANT	☐ HEART TROUBLE	_____

COMMENTS

_____

_____

PATIENT DENTAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? ☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? ☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? ☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? ☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? ☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? ☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?
   A) CLICKING? ☐
   B) PAIN (JOINT, EAR, SIDE OF FACE)? ☐
   C) DIFFICULTY IN OPENING OR CLOSING? ☐
   D) DIFFICULTY IN CHEWING? ☐
8. DO YOU HAVE FREQUENT HEADACHES? ☐
9. DO YOU CLENCH OR GRIND YOUR TEETH? ☐
10. DO YOU BITE YOUR LIPS OR CHEEKS, FREQUENTLY? ☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? ☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK? ☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? ☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? ☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? ☐

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 _____ DATE _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR