**NAME:** **DATE:**

## Medical History

| | Yes | No |
|---|---|---|
| Do you have any CURRENT HEALTH PROBLEMS? | ○ | ○ |
| Are you under a PHYSICIAN'S CARE now? | ○ | ○ |

For what? _____

What medications are you taking? _____

_____

FAMILY PHYSICIAN _____

Phone No._____

| | | |
|---|---|---|
| Do you smoke? | ○ | ○ |
| Have you ever been prescribed bisphosphonates? | ○ | ○ |
| (Women) Are you pregnant? How many months? | ○ | ○ |

### DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Material Allergies (Latex, metal, chemicals) | ○ | ○ | Radiation Treatment | ○ | ○ |
| Fen-Phen/Redux | ○ | ○ | Arthritis | ○ | ○ |
| High Blood Pressure | ○ | ○ | AIDS/HIV | ○ | ○ |
| Heart Murmur | ○ | ○ | Hepatitis A(Infectious) | ○ | ○ |
| Rheumatic Fever | ○ | ○ | Hepatitis B (Serum) | ○ | ○ |
| Congenital Heart Lesions | ○ | ○ | Liver Disease | ○ | ○ |
| Mitral Valve Prolapse | ○ | ○ | Psychiatric Treatment | ○ | ○ |
| Heart Pacemaker | ○ | ○ | Glaucoma | ○ | ○ |
| Heart Surgery | ○ | ○ | Chemotherapy | ○ | ○ |
| Artificial Joints | ○ | ○ | Cancer or Leukemia | ○ | ○ |
| Stroke | ○ | ○ | Venereal Disease | ○ | ○ |
| Kidney Trouble | ○ | ○ | Bruise Easily | ○ | ○ |
| Allergies or Hives | ○ | ○ | Emphysema | ○ | ○ |
| Asthma or Hay Fever | ○ | ○ | Tuberculosis | ○ | ○ |
| Diabetes | ○ | ○ | Epilepsy or Seizures | ○ | ○ |
| Thyroid Disease | ○ | ○ | Drug Addiction | ○ | ○ |
| Osteoporosis | ○ | ○ | Hemophilia | ○ | ○ |
| | | | Other | ○ | ○ |

## Dental History

How long since your last dental visit?_____

DATE of last dental exam _____

DATE of last X-rays _____

| | YES | NO |
|---|---|---|
| Do you currently have any dental pain? | ○ | ○ |
| Do your gums bleed or feel tender or irritated? | ○ | ○ |
| Are your teeth sensitive to hot, cold, sweets or pressure? | ○ | ○ |
| Are you unhappy with the appearance of your teeth? | ○ | ○ |
| Are you aware of grinding or clenching your teeth? | ○ | ○ |
| Do you have headaches, earaches, or neck pain? | ○ | ○ |
| Have you had orthodontic treatment (braces) before? | ○ | ○ |
| Do you have any clicking or popping in your jaw? | ○ | ○ |
| Do you feel you have bad breath? | ○ | ○ |
| Do you regularly use dental floss? | ○ | ○ |
| Does food catch between your teeth? | ○ | ○ |
| Have you had any periodontal (gum) treatment? | ○ | ○ |
| Have you ever had your teeth whitened? | ○ | ○ |
| Would you like to have whiter teeth? | ○ | ○ |
| Would you like your smile to look better or different? | ○ | ○ |

### ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin ☐ Local Anesthetic ☐ Erythromycin ☐

Nitrous Oxide ☐ Codeine ☐ Penicillin ☐

None of the above ☐

Are you allergic to any other medications or substances? Y ○ N ○

If yes, specify:_____

Is there any other Medical or Dental information that you feel we should know about? _____

_____

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered and 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 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.

**DATE:**_____ **SIGNATURE** _____

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