Patient Medical History

Name: ______ DOB: ______

Physician: ______ Phone Number ______ Last Visit: ______

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain	☐	☐

______

______

	Yes	No
3. Are you taking any medication(s) including non-prescription medicine (OTC)? If yes, what medication(s)	☐	☐

______

______

	Yes	No
4. Do you use tobacco?......................................	☐	☐
5. Do you use controlled substances?	☐	☐
6. Do you take Bisphosphonates (fosamax, didronel, boniva, actinel)	☐	☐

7. Do you have or have you had any of the following?

	Yes	No
Heart Disease	☐	☐
Rheumatic Fever	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Heart Murmer	☐	☐
Angina / Chest Pains	☐	☐
Easily Winded	☐	☐
Cardiac Pacemaker	☐	☐
Swollen Ankles	☐	☐
Mitral Valve Prolapse	☐	☐
Anemia	☐	☐
Abnormal Bleeding	☐	☐
Osteoporosis	☐	☐

	Yes	No
Bruising Easily	☐	☐
Stroke	☐	☐
Epilepsy / Convulsions	☐	☐
Fainting / Seizures	☐	☐
Frequently Tired	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐
Hey Fever / Allergies	☐	☐
Respiratory Problems	☐	☐
Asthma	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
Thyroid Problem	☐	☐

	Yes	No
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Cancer	☐	☐
Leukemia	☐	☐
Radiation Therapy	☐	☐
Stomach Trouble / Ulcers	☐	☐
Liver Disease	☐	☐
Hepatitis / Jaundice	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Sexually Transmitted Disease	☐	☐
Aids or HIV Infection	☐	☐
Other ______	☐	☐

8. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetic (eg. Novacaine)	☐	☐
Penicillin or any Other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (eg. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other ______	☐	☐

9. Women Only

	Yes	No
Are you pregnant or think you might be?	☐	☐
Are you nursing?	☐	☐
Are you taking contraceptives?	☐	☐

Dental History

Previous Dentist ______ Address ______

City ______ State ______ Zip Code ______ Date of Last Dental Exam ______

	Yes	No
1. Do you 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 in 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 experienced any of the following in your jaw:		
Clicking?	☐	☐
Pain (joint, ear, side of face)?	☐	☐
Difficulty in opening or closing?	☐	☐
Difficulty in chewing?	☐	☐

	Yes	No
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?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had an orthodontic treatment?	☐	☐
14. Do you were dentures or partials?	☐	☐
15. Do you like your smile?	☐	☐

Authorization an Release

I certify that I 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 records of any treatment or examination rendered to me or my child 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 than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or Parent if minor) ______________________ Date ______________