

Medical History

Physician's name _____ Phone # _____

When was your last physical exam? _____

Are you currently receiving medical care? Yes _____ No _____

If yes please explain. _____

Have you had any other serious illness, hospitalization or accidents? Yes _____ No _____

If yes please explain _____

Please list any Prescription and over the counter drugs, (including vitamins or herbal supplements).

Please also include dosages and why you are taking them.

For Women;

Are you taking birth control? Yes _____ No _____ Are you pregnant? Yes _____ No _____ Due date _____

Are you nursing? Yes _____ No _____

Are you allergic to any of the following? Yes or No

____ Aspirin ____ Penicillin ____ Jewelry/Metal ____ Codine ____ Amoxicillin ____ Dental anesthetics

____ Ibuprofen ____ Erythromycin ____ Latex ____ Vicodin ____ Tetracycline ____ Sulfa

Please list any other drugs/materials _____

Have you had any of the following diseases or medical problems? Please circle yes or no for each item.

Y N Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Artificial bones/joint implants <input type="checkbox"/> <input type="checkbox"/>	Y N Heart surgery
Y N Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Artificial Valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Blood transfusion
Y N Diabetes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Emphysema
Y N Epilepsy/seizure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Congenital heart defect <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Fainting spells
Y N Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Difficulty breathing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Heart murmur
Y N Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Fever blisters/Herpes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Heart attack/Stroke
Y N HIV/AIDS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Hemophilia/Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Hepatitis Type _____
Y N Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N High/Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Mitral Valve Prolapse
Y N Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Psychiatric problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Radiation treatment
Y N Venereal disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Rheumatic/Scarlet fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Sinus problems
Y N Thyroid problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Y N Osteoporosis/Osteopenia

Y N Cancer/chemotherapy - Type _____ Other _____

Dental History:

Last dental visit _____ Previous Dentists Name _____

Have you ever taken bisphosphanate drugs? (Fosomax, Reclast, Evista) ____ Y ____ N

Do you require antibiotics before dental treatment? Y N Why? _____

Do you currently have a toothache? Y N

Have you ever been treated for gum disease? Y N

Do you like your smile? Y N

Would you like whiter teeth? Y N

Have you whitened your teeth in the past? Y N When? _____ What product? _____

Is your drinking water fluoridated? Y N

Have you ever had a serious/difficult problem associated with any previous dental work? Y N

Do you now or have you ever experienced pain/discomfort in your jaw joint? Y N

Have you been recommended dental work that you haven't had done yet? Y N

How many cans of pop do you drink? _____

Anything else that would be valuable for me to know? _____

Have you ever used tobacco in any form? Y N Explain _____

AUTHORIZATION (All Patients or Guardians must sign)

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or credit information. I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

_____ Date _____

Patient's or Guardian's Signature