

Patient Medical History

Patient Name: _____
 Physician _____ Physician's Phone # _____ Date of last exam _____

	YES	NO		YES	NO	
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have or have you ever had the following?	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical procedure or serious illness within the last 5 years? If yes, explain _____	<input type="checkbox"/>	<input type="checkbox"/>		Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine? List _____	<input type="checkbox"/>	<input type="checkbox"/>		Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you taking or have you ever taken bisphosphonates (Fosamax, Actonel, Zometa, Boniva)?	<input type="checkbox"/>	<input type="checkbox"/>		Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>		Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you allergic to or have you had any reaction to the following? Local anesthetics (eg. Novacaine)	<input type="checkbox"/>	<input type="checkbox"/>		Epilepsy/ Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	
Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV+	<input type="checkbox"/>	<input type="checkbox"/>	
Any metals (eg. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	
Latex rubber	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	
	YES	NO	Angina	<input type="checkbox"/>	<input type="checkbox"/>	
8. Women only:			Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
			Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	
			Hepatitis/ Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	
			Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	
			Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	
			Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	
			Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
			Hay fever/ Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
			Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
			Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	
			Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	
			Respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>	
			Other _____	<input type="checkbox"/>	<input type="checkbox"/>	

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

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 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, 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. I authorize the dentist to use my records, photos, x-rays and models for educational purposes.

Signature of patient (or parent, if minor) _____ Date _____