PATIENT MEDICAL HISTORY

	Yes	No
Are you under medical treatment now?	□	□
Have you ever been hospitalized for any surgical operation or serious illness in the last 5 years?.....	□	□
If Yes, Please explain_____ _____		
Are you taking any prescription and/or Non-prescription medication?	□	□
If Yes, what medications? _____ _____		
What antibiotics and pain medication work best for you?_____		
Do you use tobacco products?	□	□
Do you use controlled substances?	□	□
Do you wear contact lenses or glasses?	□	□

	Yes	No
Are you allergic to or have you had any reactions to the following…		
Local Anesthetics (eg. Novocaine)	□	□
Penicillin……..	□	□
Any other type of antibiotic…….	□	□
Sulfa Drugs……	□	□
Barbiturates……..	□	□
Sedatives……	□	□
Iodine……	□	□
Aspirin……	□	□
Metals (eg. Nickel, Mercury, etc.)…	□	□
Latex Rubber……	□	□
Other: ……	□	□
Women Only:		
Are you taking oral contraceptives?	□	□
Are you pregnant or think you may be?	□	□
Are you nursing? .....□		□

Physician: _____ Office Phone:_____ Date of Last Exam:_____

Do you have or have had any of the following…….

	Yes	No		Yes	No		Yes	No
Aids or HIV Infection……	□	□	Frequently Tired……	□	□	Mitral Valve Prolapse….	□	□
Anemia……	□	□	Glaucoma……	□	□	Radiation Therapy…….	□	□
Angina……	□	□	Hay Fever/Allergies……	□	□	Recent Weight Loss……	□	□
Arthritis……	□	□	Heart Attack……	□	□	Respiratory Problems….	□	□
Asthma……	□	□	Heart Disease……	□	□	Rheumatic Fever……	□	□
Cancer……	□	□	Heart Murmur……	□	□	Sexually Transmitted		
Cardiac Pacemaker……	□	□	Hepatitis/Jaundice……	□	□	Disease……	□	□
Chest Pains……	□	□	High Blood Pressure……	□	□	Stomach Trouble……	□	□
Diabetes……	□	□	Joint Replacement……	□	□	Stroke……	□	□
Emphysema……	□	□	Kidney Disease……	□	□	Swollen Ankles……	□	□
Epilepsy/Convulsions….	□	□	Leukemia……	□	□	Thyroid Problem……	□	□
Easily Winded……	□	□	Liver Disease……	□	□	Tuberculosis……	□	□
Fainting/Seizures……	□	□	Low Blood Pressure……	□	□	Ulcers……	□	□

Other: _____

PATIENT DENTAL HISTORY

Name of Previous Dentist: _____ Date of Last Cleaning and Exam:_____

Why did you leave your previous dentist? _____

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing?	□	□	Are your teeth sensitive to hot or cold?	□	□
Are your teeth sensitive to sweet or sour foods?	□	□	Do you like your smile?	□	□

Do you have any dental concerns you would like for us to address today? _____

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 record of any treatment or examination rendered to me oy 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. I agree to be responsible for payment of all fees not paid by my insurance company

X_____ (Signature of Patient or Parent/Guardian if patient is a minor)