

# Patient Medical History

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_  
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_  
Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_  
Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_  
Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No \_\_\_\_\_  
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No \_\_\_\_\_  
Are you on a special diet? ☐ Yes ☐ No  
Do you use tobacco? ☐ Yes ☐ No  
Do you use controlled substances? ☐ Yes ☐ No

Women: Are you

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs  
☐ Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problem <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

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

X

Signature of patient (or parent/guardian if minor) \_\_\_\_\_

Date \_\_\_\_\_

Doctor's Comments \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_