PATIENT'S MEDICAL HISTORY

PATIENTS NAME_____ DATE OF BIRTH_____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY, HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

		YES	NO			YES	NO
1	ARE YOU IN GOOD HEALTH			12	HAVE YOU EVER TAKEN FEN-PHEN/REDUX		
2	HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR			13	HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHOSHONATES?		
3	DATE OF YOUR LAST PHYSICAL EXAM:			14	HAVE YOU TAKEN VIAGRA, REVATIO, CIALIS OR LAVITRA IN THE LAST 24 HOURS?		
4	PHYSICIAN'S NAME: ADDRESS: PHONE NO.			15	DO YOU USE TOBACCO?		
5	ARE YOU NOW UNDER THE CARE OF A PHYSICIAN			16	DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES		
6	HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS. PLEASE EXPLAIN:			17.	ARE YOU WEARING CONTACT LENSES?		
7	ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE. IF YES, WHAT MEDICINES(S) ARE YOU TAKING			18	DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS).		
8	HAVE YOU HAD ANY ABNORMAL BLEEDING			19.	DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT		
9	DO YOU BRUISE EASILY			WOMEN ONLY: ARE YOU PREGNANT OR THINK YOU ARE PREGNANT ARE YOU NURSING ARE YOU TAKING BIRTH CONTROL PILLS			
10	HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION						
11	HAVE YOU HAD A RECENT WEIGHT LOSS						

	YES	NO		YES	NO
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:			HIVES OR SKIN RASH		
LOCAL ANESTHETICS LIKE NOVOCAINE			FAINTING OR DIZZY SPELLS		
PENICILLIN OR OTHER ANTIBIOTICS			DIABETES		
SULFA DRUGS			AIDS OR HIV INFECTION		
BARBITURATES, SEDATIVES OR SLEEPING PILLS			THYROID PROBLEMS		
ASPIRIN			ALLERGIES		
IODINE			ARTHRITIS OR RHEUMATISM		
ANY METALS (e.g., NICKEL OR MERCURY, ETC)			JOINT REPLACEMENT OR IMPLANT		
LATEX/RUBBER			STOMACH ULCER		
OTHER (PLEASE LIST)			KIDNEY TROUBLE		
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:			TUBERCULOSIS		
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER			PERSISTENT COUGH		
SCARLET FEVER			COUGH THAT PRODUCES BLOOD		
HEART DEFECT OR HEART MURMUR			CHEMOTHERAPY (CANCER, LEUKEMIA)		
HEART TROUBLE, HEART ATTACK, OR ANGINA			SEXUALLY TRANSMITTED DISEASE		
CHEST PAIN			EPILEPSY OR SEIZURES		
SHORTNESS OF BREATH			ANEMIA		
PACEMAKER			GLAUCOMA		
HEART SURGERY			NERVOUSNESS		
HIGH/LOW BLOOD PRESSURE			TONSILLITIS		
CONGENITAL HEART PROBLEM			TUMORS		
SWELLING OF FEET, ANKLES, HANDS			MENTAL HEALTH CARE		
HEPATITIS, JAUNDICE OR LIVER DISEASE			BACK PROBLEMS		
STROKE			CHEMICAL DEPENDENCY		
SINUS TROUBLE			MITRAL VALVE PROLAPSE		
LUNG OR BREATHING PROBLEMS			CORTISONE TREATMENT		
ASTHMA OR HAY FEVER			COLD SORES/FEVER BLISTERS		
HYPOGLYCEMIA			EATING DISORDERS		

PATIENT'S DENTAL HISTORY

PATIENT'S NAME_____ DATE OF BIRTH_____

REASON FOR THIS VISIT_____
WHEN WAS YOUR LAST DENTAL VISIT_____ WHAT WAS DONE_____
HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN_____
PREVIOUS DENTIST (NAME AND LOCATION)_____
HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN/WHERE_____
HOW OFTEN DO YOU BRUSH YOUR TEETH_____ HOW OFTEN DO YOU FLOSS YOUR TEETH_____
IS YOUR DRINKING WATER FLUORIDATED_____

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING			DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY		
ARE YOUR TEETH SENSITIVE TO HOLD OR COLD LIQUIDS/FOODS			HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH		
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS			DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH		
DO YOU FEEL PAIN TO ANY OF YOUR TEETH			HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)		
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH			EVER WORN A BITE PLATE OR OTHER APPLIANCE		
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES			HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS		
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS WITH YOUR JAW			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS		
CLICKING			DO YOU WEAR DENTURES OR PARTIALS ~ IF YES, DATE OF PLACEMENT		
PAIN (JOINT, EAR, SIDE OF FACE)			HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS		
DIFFICULTY IN OPENING OR CLOSING					
DO YOU HAVE FREQUENT HEADACHES					
DO YOU CLENCH OR GRIND YOUR TEETH					

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

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_____DATE_____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR.

DOCTOR'S COMMENTS _____
_____
_____
_____

_____
SIGNATURE DATE