

## Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Last Date of Exam \_\_\_\_\_

<p>1. Are you under any medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain _____</p> <p>3. Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Have you ever taken Fen-Phen/Redux? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>9.</p>	<p>Are you allergic to or have to had any reactions to the following?</p> <table border="0"> <tr> <td></td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td>Local Anesthetics (e.g. Novocain).....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Penicillin or other Antibiotics.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Sulfa Drugs.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Barbiturates.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Sedatives.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Iodine.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Aspirin.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Any Metals (e.g. nickel, mercury, etc.).....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Latex Rubber.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other (please list) _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Women Only:</p> <p>a) Are you pregnant or think you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Are you taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		Yes	No	Local Anesthetics (e.g. Novocain).....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates.....	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives.....	<input type="checkbox"/>	<input type="checkbox"/>	Iodine.....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	Latex Rubber.....	<input type="checkbox"/>	<input type="checkbox"/>	Other (please list) _____	<input type="checkbox"/>	<input type="checkbox"/>
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## Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

<p>1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you feel any pain in your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you have any soars or lumps in your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you had any head, neck, or jaw injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever experienced any of the following problems in your jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clicking? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain (joint, ear, side of face)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty in opening or closing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty in chewing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>8.</p>	<p>Do you have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do your bite you lips or cheeks frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever had any difficult extractions in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you ever had any prolonged bleeding following extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Have you had any orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you wear dentures or partials? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of placement _____</p> <p>15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Do you like your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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## 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 if minor)

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

Signature \_\_\_\_\_ Date \_\_\_\_\_