



Patient Medical History for _____ (name)

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now? YES NO
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? YES NO
If yes, please explain _____
3. Are you taking any medication(s) including non-prescription medicine? YES NO
If yes, what medication(s) are you taking? _____
4. Do you use tobacco? YES NO

5. Do you have or have you had any of the following?

- | | YES | NO |
|------------------------------|--------------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting / Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy / Convulsions | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> |
| Down's Syndrome | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|------------------------------------|--------------------------|--------------------------|
| Mentally Handicapped | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequently Tired | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Replacement or Implant | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis / Jaundice | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach Troubles / Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |

6. Are you allergic to or have you had any reactions to the following? YES NO
- Local Anesthetics (e.g. Novocaine) YES NO
- Penicillin or any other Antibiotics YES NO
- Sulfa Drugs YES NO
- Barbiturates..... YES NO
- Sedatives..... YES NO
- Iodine..... YES NO
- Aspirin..... YES NO
- Any Metals (e.g. nickel, mercury, etc.)..... YES NO
- Latex Rubber..... YES NO
- Other (please list)..... YES NO
7. Do you have any medical condition about which we should know? Please explain _____

8. Women only:

- a) Are you pregnant or think you may be pregnant? YES NO
- b) Are you nursing? YES NO
- c) Are you taking oral contraceptives? YES NO

- | | YES | NO | | YES | NO |
|-----------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Chest Pains..... | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Hay Fever / Allergies | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis..... | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Trouble..... | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory Problems..... | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse..... | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | | <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"/> | 9. Do you clench or grind your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods?..... | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods?..... | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions?..... | <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"/> | 13. Have you ever had any orthodontic treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries?..... | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you wear dentures or partials? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in you jaw? | | | If yes, date of placement _____ | | |
| Clicking | <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you like your smile?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain (joint, ear, side of face)..... | <input type="checkbox"/> | <input type="checkbox"/> | 16. Children: | | |
| Difficulty in opening or closing..... | <input type="checkbox"/> | <input type="checkbox"/> | Any finger or thumb habits (thumb sucking etc)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in chewing..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 8. Do you have frequent headaches?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved.

This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental service that I may need during diagnosis and treatment, with my informed consent.

X

Signature of parent (or parent/guardian)

Date