

Patient's Name: _____

MEDICAL HISTORY

PATIENT PLEASE COMPLETE

1. When were your teeth cleaned last? _____
2. Are you having pain or discomfort in any of your teeth? ☐ YES ☐ NO
3. Do you feel nervous about having dental treatment? ☐ YES ☐ NO
4. Have you ever had a bad experience in a dental office? ☐ YES ☐ NO
5. Have you been a patient in the hospital during the last two years? ☐ YES ☐ NO
6. Have you been under the care of a medical doctor during the past two years for other than routine exams, and if so, WHY? ☐ YES ☐ NO
7. Are you taking any medicine or drugs? (If so, name)..... ☐ YES ☐ NO
8. Are you allergic to or made sick by penicillin, latex, aspirin, codeine, or any other drugs or medications?
Please describe _____ ☐ YES ☐ NO
9. Have you ever taken Phen Phen or Redux Medicines?..... ☐ YES ☐ NO
10. Have you ever had any excessive bleeding requiring special treatment? ☐ YES ☐ NO
11. Do you take or ever taken Biphosphonates(Fosamax, Boniva, Actonel, Aredia, Zometa etc.) for Osteoporosis or any other condition?..... ☐ YES ☐ NO

*** Please answer YES or NO***

* REQUIRES PREMEDICATION

YES NO

- ☐ ☐ Artificial Heart Valve*
- ☐ ☐ Heart Murmur*
- ☐ ☐ Rheumatic Fever*
- ☐ ☐ Mitral Valve Prolapse*
- ☐ ☐ Artificial Joint*
- ☐ ☐ Congenital Heart Lesions
- ☐ ☐ Heart Pacemaker
- ☐ ☐ Heart/Bypass Surgery
- ☐ ☐ Heart Disease/Attack
- ☐ ☐ Angina Pectoris
- ☐ ☐ High Blood Pressure

YES NO

- ☐ ☐ Stroke
- ☐ ☐ Kidney Trouble
- ☐ ☐ Ulcers
- ☐ ☐ Emphysema
- ☐ ☐ Tuberculosis
- ☐ ☐ Asthma
- ☐ ☐ Sinus Trouble
- ☐ ☐ Allergies
- ☐ ☐ Diabetes
- ☐ ☐ Thyroid Disease
- ☐ ☐ Scarlet Fever

YES NO

- ☐ ☐ Chemotherapy
- ☐ ☐ Liver disease
- ☐ ☐ Arthritis
- ☐ ☐ Rheumatism
- ☐ ☐ Glaucoma
- ☐ ☐ Epilepsy or Seizures
- ☐ ☐ Fainting or Dizzy Spells
- ☐ ☐ Sickle Cell Disease
- ☐ ☐ Psychiatric Treatment
- ☐ ☐ Bruise Easily
- ☐ ☐ Periodontal Disease

YES NO

- ☐ ☐ Hepatitis A
- ☐ ☐ Hepatitis B
- ☐ ☐ HIV
- ☐ ☐ Yellow Jaundice
- ☐ ☐ Blood Transfusion
- ☐ ☐ Drug Addiction
- ☐ ☐ Hemophilia
- ☐ ☐ Syphilis
- ☐ ☐ Gonorrhea
- ☐ ☐ Cold Sores
- ☐ ☐ Herpes

*Medical Doctor's Name: _____ Phone#: _____

11. When you walk up stairs, do you ever have to stop because of pain
In your chest, or shortness of breath, or because you are very tired?..... YES NO
13. Do your ankles swell during the day?..... YES NO
14. Has your medical doctor ever said you have cancer or a tumor? YES NO
15. Do you have any disease, condition, or problem not listed? If so, name..... YES NO
16. Do you smoke or use tobacco?..... YES NO
17. WOMEN: Are you pregnant now?..... YES NO
If yes, how many months? _____

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.

Date

Dr. Signature

Signature of Patient, Parent or Guardian

Date

Addition

Patient Signature

Dr. Signature