

Name \_\_\_\_\_

### Medical

Physician _____	Phone # _____	Date of last exam _____						
	Yes      No		Yes      No					
1. Are you under medical treatment now?	___	___	10. Are you allergic to or have you had any reactions to the following?	___	___			
2. Have you ever been hospitalized for any operation or serious illness? If yes, please explain: _____	___	___	Local Anesthetics (Novocain)	___	___			
3. Are you taking any medications including non-prescription medications? Please list: _____	___	___	Latex	___	___			
_____			Penicillin or any antibiotic	___	___			
_____			Sulfa drugs	___	___			
_____			Barbiturates	___	___			
4. Have you ever taken Phen-Fen/Redux?	___	___	Sedatives	___	___			
5. Do you use tobacco?	___	___	Iodine	___	___			
6. Do you use controlled substances?	___	___	Aspirin	___	___			
7. Are you wearing contact lenses?	___	___	Metals (nickel, mercury)	___	___			
8. Are you pregnant or think you might be?	___	___	Other: _____	___	___			
9. Please check all that apply:	___	___	11. Are you taking oral contraceptives?	___	___			
	Yes      No		12. Are you nursing?	___	___			
Aids/HIV infection	___	___	13. Do you take an aspirin daily?	___	___			
Allergies/Hay Fever	___	___						
Anemia	___	___	Yes      No	Yes      No	Yes      No			
Angina/Chest Pain	___	___	Emphysema/Winded	___	___	Implant	___	___
Arthritis	___	___	Epilepsy/Convulsions	___	___	Joint Replacement	___	___
Asthma	___	___	Fainting/Seizures	___	___	Kidney Disease	___	___
Cancer	___	___	Glaucoma	___	___	Leukemia	___	___
Cardiac Pacemaker	___	___	Heart Attack	___	___	Liver Disease	___	___
Diabetes	___	___	Heart Disease/Defect	___	___	Low Blood Pressure	___	___
Recent Weight Loss	___	___	Heart Murmur	___	___	Mitral Valve Prolapse	___	___
STD	___	___	Hepatitis/Jaundice	___	___	Osteoporosis	___	___
Thyroid Problems	___	___	High Blood Pressure	___	___	Radiation Therapy	___	___
Abnormal bleeding	___	___	Respiratory Problems	___	___	Rheumatic Fever	___	___
Chemotherapy	___	___	Ulcer/Gurd	___	___	Swollen Ankles	___	___
Blood transfusion	___	___	Tuberculosis	___	___	Stroke	___	___
Sickle cell	___	___	Alcohol/drug abuse	___	___	Artificial valves	___	___
Steroid therapy	___	___	Lupus	___	___	Psychiatric treatment	___	___
			Herpes	___	___	Cold sores/fever blisters	___	___
			Shingles	___	___	Hemophilia	___	___
			Other _____	___	___			

### Dental

Previous Dentist _____	Phone # _____	Last Cleaning/Exam _____			
	Yes      No		Yes      No		
1. Do your gums bleed while brushing/ flossing?	___	___	9. Do you have frequent headaches?	___	___
2. Are your teeth sensitive to hot or cold?	___	___	10. Do you clench or grind your teeth?	___	___
3. Have you ever been diagnosed with gum/periodontal disease?	___	___	11. Do you bite your lips or cheeks?	___	___
4. Do you feel pain in any of your teeth?	___	___	12. Have you ever had treatment for periodontal disease?	___	___
5. Do you have any sores/lumps in mouth?	___	___	13. Have you had a difficult extraction?	___	___
6. Have you had head, neck or jaw injuries?	___	___	14. Have you had prolonged bleeding after an extraction?	___	___
7. Have you experienced the following problems in your jaw?			15. Have you had orthodontics?	___	___
Clicking	___	___	16. Do you wear dentures or partials? If yes, date of placement _____	___	___
Pain (joint, ear, side of face)	___	___	17. Have you received oral hygiene instructions on gum/teeth care?	___	___
Difficulty opening/closing your mouth	___	___	18. Do you like your smile?	___	___
Difficulty in chewing	___	___			
8. Have you ever required antibiotics before dental treatment?	___	___			

### 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/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.**

Your Signature X \_\_\_\_\_ Date \_\_\_\_\_