PATIENT NAME: DATE:

Chief Concern(s):					
Facial Injuries:					
Current Medications:					
Drug Allergies:					
Previous surgeries and/or hospitalizations:					
Y	N	HIGH BLOOD PRESSURE	Y	N	SHINGLES OR HERPES
Y	N	CHEST PAINS	Y	N	(POSSIBLY) PREGNANT
Y	N	STROKE	Y	N	BIRTH CONTROL PILLS
Y	N	RHEUMATIC FEVER	Y	N	DRINK COFFEE
Y	N	SHORTNESS OF BREATH	Y	N	USE TOBACCO
Y	N	HEART TROUBLE OR MURMUR	Y	N	CONSUME ALCOHOLIC DRINKS
Y	N	PROSTHETIC DEVICES	Y	N	JAW JOINT DIFFICULTIES
Y	N	LUNG DISEASE	Y	N	SORE JAWS
Y	N	ASTHMA	Y	N	FREQUENT HEADACHES
Y	N	ALLERGIES OR HAY FEVER	Y	N	DIZZY OR PAIN IN EARS
Y	N	SINUS PROBLEMS	Y	N	TENDER JAW, NECK OR BACK
Y	N	MOUTH BREATHING	Y	N	HISTORY OF TMJ PROBLEMS
Y	N	ULCERS OR STOMACH PROBLEMS	Y	N	GUM DISEASE
Y	N	DIABETES	Y	N	PRIOR ORTHODONTIC THERAPY
Y	N	HEPATITIS OR LIVER DISEASE	Y	N	PRIOR ORAL SURGERY
Y	N	KIDNEY DISEASE	Y	N	X-RAYS IN THE PRIOR YEAR
Y	N	THYROID TROUBLE	Y	N	FEAR OF DENTAL TREATMENT
Y	N	CONNECTIVE TISSUE DISEASE	Y	N	BRUSH TEETH DAILY
Y	N	SEXUALLY TRANSMITTED DISEASE	Y	N	FLOSS TEETH DAILY
Y	N	ARTHRITIS	Y	N	BAD BREATH
Y	N	CANCER	Y	N	BLEEDING GUMS
Y	N	OTHER SERIOUS ILLNESS	Y	N	SENSITIVE OR SORE TEETH
Y	N	PROLONGED BLEEDING,BRUISE EASILY	Y	N	FEVER BLISTERS OR MOUTH ULCERS
Y	N	CONTACT LENSES	Y	N	SPEECH PROBLEMS
Y	N	GLAUCOMA	Y	N	LIP BITING
Y	N	EPILEPSY	Y	N	THUMB/FINGER SUCKING
Y	N	PSYCHIATRIC THERAPY	Y	N	TONGUE THRUSTING HABIT
Y	N	HIV+ AND/OR AIDS	Y	N	GAG EASILY
Y	N	EXPOSED TO HIV OR BLOOD TRANSFUSION	Y	N	NAIL BITING
Y	N	TESTED FOR HIV	Y	N	GRINDING/CLENCHING
Y	N	RADIATION TREATMENT	Y	N	WANT TO KEEP NATURAL TEETH

Dental History Notes:

Medical History Notes:

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the dental staff to perform the necessary dental services as needed during diagnosis and treatment. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

SIGNATURE: DATE: