Medical History Information

Physician: _____ **Office Number:** _____ **Date of Last Exam:** _____

Who do we notify in the case of an emergency? _____**Phone #**_____

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 including non-prescription medicine?** **YES** **NO**
If YES, please list medications: _____
_____

4. **Have you ever taken medications for osteoporosis?** **YES** **NO** **If so, please list**_____

5. **Are you taking any Blood Thinners?** **YES** **NO** **If so, please list**_____

6. **Do you use tobacco?** **YES** **NO**

7. **Are you allergic to or have you had any reactions to the following:**

Local Anesthetics	**Antibiotics** _____	**Pain Medications**_____
Aspirin	**Latex Rubber**	
Sedatives	**Metals**	**Other:** _____

8. **Women Only:**
Are you pregnant or think you may be pregnant? **YES** **NO**
Are you nursing? **YES** **NO**
Are you taking oral contraceptives? **YES** **NO**

Do you have or have you had any of the following? **Please circle those that apply.**

High Blood Pressure	**Osteoporosis**	**Diabetes**	**Hepatitis A, B, Or C**
Cardiac Pacemaker	**Radiation Therapy to Head or Neck**	**Rheumatic Fever**	**Liver Disease**
Stroke	**Tuberculosis**	**Fainting/Seizures**	**Glaucoma**
Chest Pains/Angina	**Respiratory Problems**	**Thyroid Problem**	**Arthritis**
Mitral Valve Prolapse	**Asthma**	**Kidney Disease**	
Heart Disease	**Emphysema**	**AIDS/HIV +**	
Heart Attack	**Artificial Joint/Replacement**	**Cancer**_____	
Heart Murmur			
Anemia			

Other (Please List)_____

Dental History Information

Reason for Dental Visit Today: _____ **Date of Last Dental Visit:** _____

1. Do your gums bleed while brushing or flossing?	**Y/N**	**8. Do you have frequent headaches?**	**Y/N**
2. Are your teeth sensitive to hot or cold liquids/foods?	**Y/N**	**9. Do you clench or grind your teeth?**	**Y/N**
3. Are your teeth sensitive to sweet or sour liquids/foods?	**Y/N**	**10. Do you bite your lips or cheeks frequently?**	**Y/N**
4. Do you feel pain to any of your teeth?	**Y/N**	**11. Have you ever had any difficult extractions?**	**Y/N**
5. Do you feel pain to any sores or lumps in or near your mouth?	**Y/N**	**12. Have you had any orthodontic treatment?**	**Y/N**
6. Have you had any head, neck or jaw injuries?	**Y/N**	**13. Do you wear dentures or partials?**	**Y/N**
7. Have you experienced clicking/pain/difficulty in opening, closing or chewing? **YES** **NO**		**14. Have you ever received oral hygiene instructions?**	**Y/N**

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 my child or me 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:** _____ **Relationship to Patient:** _____
Signature of patient, parent or guardian

_____ **Date:** _____ **Relationship to Patient:** _____
Signature of guarantor of payment/responsible party