MEDICAL HISTORY

Primary Doctor: ____________________ Office Phone: ____________________ Date of last exam: __________

	YES	NO
1. Are you under medical treatment at this time?	☐	☐
2. Are you currently being treated for a psychological disorder?	☐	☐
3. Do you use tobacco?	☐	☐
4. Do you use a controlled substance?	☐	☐
5. Are you taking any blood thinners?	☐	☐
6. Are you taking any **BISPHOSPHONATES**? Or other medications for **osteoporosis**?	☐	☐
7. Are you currently under **pain management**?	☐	☐
8. Have you ever taken Phen-Fen / Redux?	☐	☐

9. Please list all MEDICATIONS you are currently taking:

____

____

____

____

Are you allergic to or have you ever had a reaction to the following:

	YES	NO
Local Anesthetics	☐	☐
Penicillin	☐	☐
Other Antibiotics: __________	☐	☐
Sulfa Drugs	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metal—Nickel, Mercury	☐	☐
Latex Rubber	☐	☐
Other: __________	☐	☐

WOMEN ONLY

Are you PREGNANT or think you may be pregnant? ______

Are you nursing? ______

Are you taking oral contraceptives? ______

Medical Conditions

	YES	NO
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Rheumatic Fever	☐	☐
Fainting	☐	☐
Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis ______	☐	☐
Sexually Transmitted Disease	☐	☐
Ulcers	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐
Hay fever	☐	☐
Radiation Therapy	☐	☐
Liver Disease	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapse	☐	☐
Jaundice	☐	☐
Swollen Ankles	☐	☐
Other: __________	☐	☐

Dental Conditions

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids or foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck, or jaw injuries?	☐	☐
7. Have you ever experienced any TMJ problems?	☐	☐
8. Do you clench or grind your teeth?	☐	☐
9. Do you bite your lips, tongue, or cheeks frequently?	☐	☐
10. Do you wear DENTURES or PARTIALS?	☐	☐
11. If so, how long have you had them? __________	☐	☐
12. Have you ever received orthodontic treatment?	☐	☐
13. Have you ever had any difficulties with extractions?	☐	☐
14. Have you ever had prolonged bleeding following extractions?	☐	☐
15. Have you ever been treated for periodontal disease?		

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 release of 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 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 of service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

If you could change anything about your smile, what would it be?

____

Signature of patient (or parent if minor) *Date*