MEDICAL AND DENTAL HISTORY

Patient Name:_____Date:_____

MEDICAL

Physician Name:_____ Phone:_____

Are you under the care of a physician now? ❒Yes ❒No If YES, please explain: _____

Do you currently have, or have you ever had any of the following?

Heart Failure	❒Yes ❒No	Hepatitis	❒Yes ❒No	Nervousness/Depression	❒Yes ❒No
Heart Disease/Attack	❒Yes ❒No	Liver Disease	❒Yes ❒No	Psychiatric Treatment	❒Yes ❒No
Chest Pain	❒Yes ❒No	Epilepsy or Seizures	❒Yes ❒No	Multiple Sclerosis	❒Yes ❒No
High Blood Pressure	❒Yes ❒No	Fainting/Dizzy Spells	❒Yes ❒No	Diabetes	❒Yes ❒No
Heart Murmur	❒Yes ❒No	Cancer/Leukemia	❒Yes ❒No	Thyroid Disease	❒Yes ❒No
Mitral Valve Prolapse	❒Yes ❒No	Chemotherapy	❒Yes ❒No	HIV Positive	❒Yes ❒No
Rheumatic Fever	❒Yes ❒No	Glaucoma	❒Yes ❒No	AIDS	❒Yes ❒No
Heart Defects	❒Yes ❒No	Emphysema	❒Yes ❒No	Arthritis	❒Yes ❒No
Scarlet Fever	❒Yes ❒No	Asthma	❒Yes ❒No	Pain in Jaw Joints	❒Yes ❒No
Artificial Heart Valve	❒Yes ❒No	Difficulties Breathing	❒Yes ❒No	Loss of Appetite	❒Yes ❒No
Heart Pacemaker	❒Yes ❒No	Sinus Trouble	❒Yes ❒No	Loss of Sleep	❒Yes ❒No
Heart Surgery	❒Yes ❒No	Severe Allergies/hives	❒Yes ❒No	Use a C-Pap	❒Yes ❒No
Artificial Joints/Prosthesis	❒Yes ❒No	Yellow Jaundice	❒Yes ❒No	Loud Snoring	❒Yes ❒No
Anemia	❒Yes ❒No	Drug Addiction	❒Yes ❒No	Bruise Easily	❒Yes ❒No
Stroke	❒Yes ❒No	Hemophilia	❒Yes ❒No	(Frequent) Cold Sores	❒Yes ❒No
Kidney Disease	❒Yes ❒No	Sickle Cell Disease	❒Yes ❒No	Adverse reaction to local anesthetic (Novocain)	❒Yes ❒No

Are you pregnant or trying to get pregnant? ❒Yes ❒No

Are you currently taking Birth Control Pills? ❒Yes ❒No

Are you currently taking Blood Thinners? ❒Yes ❒No

Do you have a LATEX allergy? ❒Yes ❒No

Do you smoke? ❒Yes ❒No If yes, for how long have you been a smoker? _____ How much do you smoke? _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ❒Yes ❒No

List any and all medications that you are currently taking:_____

_____

List any and all medications that you are knowingly allergic to, or have had an adverse reaction to: _____

_____

Is there any other medical information not included above which you feel we should be informed about? ❒Yes ❒No

If YES, please explain: _____

Have you ever or do you currently receive Botox Injections? ❒Yes ❒No

If YES, please indicate the nature of your treatment: ❒Therapeutic ❒Cosmetic ❒Both

DENTAL

Has the fear of discomfort kept you from regular dental visits? ❒Yes ❒No

Are you satisfied with your past dentistry? ❒Yes ❒No

Have you ever had a bad experience in a dental office? ❒Yes ❒No

Are you concerned that you may have bad breath? ❒Yes ❒No

Do your gums bleed easily, or feel tender and/or irritated? ❒Yes ❒No

Are your teeth sensitive to hot, cold and/or sweets? ❒Yes ❒No

Are there areas in your mouth where food sticks and/or gets caught? ❒Yes ❒No

Are you self-conscious about the appearance of your teeth? ❒Yes ❒No

Do your jaws often feel tired and/or sore? ❒Yes ❒No

Do you experience excessive headaches and/or neck pain? ❒Yes ❒No

Do you experience clicking/popping when opening/closing/chewing? ❒Yes ❒No

Are you aware of yourself clenching or grinding your teeth? ❒Yes ❒No

Have you ever had Orthodontic Treatment (Braces)? ❒Yes ❒No

1. What prompted you to seek dental care at this time? _____

2. Approximately how long has it been since your last dental examination & cleaning? _____

3. What, if anything, would you do to change the appearance of your teeth: *(check all that apply)*

❒Whiter ❒Straighter ❒Longer ❒ Shorter ❒ Shaped differently ❒ I would not change anything

CONSENT

I acknowledge that all of the above information is accurate to the best of my knowledge. I authorize this office and its trained staff to take x-rays & other diagnostic aids needed to make proper diagnosis of my dental needs. I authorize this office and its trained staff to perform all forms of treatment, as is indicated. I understand the use of anesthetic agents will be used when indicated & that this embodies a certain risk. I give my permission to release medical/dental information as needed to process insurance claim forms or to receive proper treatment from other health providers.

_____ _____ _____

Signature of Patient / Parent or Guardian | Dr. Signature | Date