Name_____

Medical

Physician _____ Phone # _____ Date of last exam _____

	Yes	No
1. Are you under medical treatment now?	___	___
2. Have you ever been hospitalized for any operation or serious illness? If yes, please explain: _____	___	___
3. Are you taking any medications including non-prescription medications? Please list: _____ _____ _____ _____	___	___
4. Have you ever taken Phen-Fen/Redux?	___	___
5. Do you use tobacco?	___	___
6. Do you use controlled substances?	___	___
7. Are you wearing contact lenses?	___	___
8. Are you pregnant or think you might be?	___	___

9. Please check all that apply:

	Yes	No		Yes	No		Yes	No
Aids/HIV infection	___	___	Emphysema/Winded	___	___	Implant	___	___
Allergies/Hay Fever	___	___	Epilepsy/Convulsions	___	___	Joint Replacement	___	___
Anemia	___	___	Fainting/Seizures	___	___	Kidney Disease	___	___
Angina/Chest Pain	___	___	Glaucoma	___	___	Leukemia	___	___
Arthritis	___	___	Heart Attack	___	___	Liver Disease	___	___
Asthma	___	___	Heart Disease/Defect	___	___	Low Blood Pressure	___	___
Cancer	___	___	Heart Murmur	___	___	Mitral Valve Prolapse	___	___
Cardiac Pacemaker	___	___	Hepatitis/Jaundice	___	___	Osteoporosis	___	___
Diabetes	___	___	High Blood Pressure	___	___	Radiation Therapy	___	___
Recent Weight Loss	___	___	Respiratory Problems	___	___	Rheumatic Fever	___	___
STD	___	___	Ulcer/Gurd	___	___	Swollen Ankles	___	___
Thyroid Problems	___	___	Tuberculosis	___	___	Stroke	___	___
Abnormal bleeding	___	___	Alcohol/drug abuse	___	___	Artificial valves	___	___
Chemotherapy	___	___	Lupus	___	___	Psychiatric treatment	___	___
Blood transfusion	___	___	Herpes	___	___	Cold sores/fever blisters	___	___
Sickle cell	___	___	Shingles	___	___	Hemophilia	___	___
Steroid therapy	___	___	Other _____					

	Yes	No
10. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (Novocain)	___	___
Latex	___	___
Penicillin or any antibiotic	___	___
Sulfa drugs	___	___
Barbiturates	___	___
Sedatives	___	___
Iodine	___	___
Aspirin	___	___
Metals (nickel, mercury)	___	___
Other: _____		
11. Are you taking oral contraceptives?	___	___
12. Are you nursing?	___	___
13. Do you take an aspirin daily?	___	___

Dental

Previous Dentist_____ Phone # _____ Last Cleaning/Exam _____

	Yes	No
1. Do your gums bleed while brushing/ flossing?	___	___
2. Are your teeth sensitive to hot or cold?	___	___
3. Have you ever been diagnosed with gum/ periodontal disease?	___	___
4. Do you feel pain in any of your teeth?	___	___
5. Do you have any sores/lumps in mouth?	___	___
6. Have you had head, neck or jaw injuries?	___	___
7. Have you experienced the following problems in your jaw?		
Clicking	___	___
Pain (joint, ear, side of face)	___	___
Difficulty opening/closing your mouth	___	___
Difficulty in chewing	___	___
8. Have you ever required antibiotics before dental treatment?	___	___

	Yes	No
9. Do you have frequent headaches?	___	___
10 . Do you clench or grind your teeth?	___	___
11. Do you bite your lips or cheeks?	___	___
12. Have you ever had treatment for periodontal disease?	___	___
13. Have you had a difficult extraction?	___	___
14. Have you had prolonged bleeding after an extraction?	___	___
15. Have you had orthodontics?	___	___
16. Do you wear dentures or partials?	___	___
If yes, date of placement _____		
17. Have you received oral hygiene instructions on gum/teeth care?	___	___
18. Do you like your smile?	___	___

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 _____