Medical History

Are you under a physician's care now?	Yes	No
Have you ever been hospitalized or had a major operation?	Yes	No
Have you ever had a serious head or neck injury?	Yes	No
Do you use tobacco?	Yes	No
Do you use controlled substances?	Yes	No
Are you taking any medications, pills, or drugs? Please list.		
Do you take or have you ever taken biophosponates? (ie. Fosomax/Actonel)	Yes	No
Are you on a special diet?	Yes	No

Women: Are you

Pregnant/trying to get pregnant	Yes	No	Taking oral contraceptives?	Yes	No	Nursing	Yes No

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic	metal
Local anesthetics	Latex	None		

Other (please explain)_____

Do you have, or have you had any of the following, Please circle if 'yes'.

AIDS/HIV Positive	Convulsions	Hepatitis A	Scarlet Fever
Alzheimer's Disease	Cortisone Medicine	Hepatitis B or C	Shingles
Anaphylaxis	Diabetes	Herpes	Sickle Cell Disease
Anemia	Drug Addiction	High Blood Pressure	Sinus Trouble
Angina Pectoris	Easily Winded	Hives or Rash	Special Diet
Arthritis/Gout/Rheumatism	Emphysema	Hypoglycemia	Spina Bifida
Artificial Heart Valve(s)	Epilepsy or Seizures	Irregular Heartbeat	Stomach/Intestinal issues
Artificial Joint(s)	Excessive Bleeding	Kidney Problems	Stroke
Aspirin Taken Daily	Excessive Thirst	Leukemia	Swelling of the Limbs

Asthma	Fainting Spells/Dizziness	Liver Disease	Tonsillitis
Back Problems	Frequent Cough	Low Blood Pressure	Tuberculosis
Blood Disease	Frequent Diarrhea	Lung Disease	Tumors/Growths
Blood Transfusion	Frequent Headaches	Mitral Valve Prolapse	Ulcers
Breathing Problem	Genital Herpes	Pain in Jaw Joints	Venereal Disease
Bruise Easily	Glaucoma	Parathyroid Disease	Yellow Jaundice
Cancer	Hay Fever/Allergies	Psychiatric Care	
Chemotherapy	Heart Attack/Heart Failure	Radiation Treatments	
Chest Pains	Heart Murmur	Recent Weight Loss	
Circulatory Problems	Heart Pacemaker	Renal Dialysis	
Cold Sores/Fever Blisters	Heart Trouble/Disease	Rheumatic Fever	
Congenital Heart Disorder	Hemophilia	Rheumatism	

Have you ever had any serious illnesses not listed above? If yes, please explain._____

Do you have high cholesterol? Yes No
Have you ever responded adversely to medical or dental treatment? Yes No
If patient is a child, what is his/her weight? _____
Have you ever been advised to be premedicated prior to any dental procedure? Yes No
Is there anything else we should know about your medical history? _____
_____
Comments:

Date of last dental exam/cleaning? _____

I have verbally reviewed the medical/dental information above with the parent/guardian/ or patient named herein.
Staff/Dr. initials_____ Date_____

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 acurately answered. I understand that providing incorrect information can be dancerour 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 payers and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist/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 dependants.

Signature of Patient/parent if minor_____

Date_____

Dental History

Do you:

Clench or grind your teeth while awake or asleep? Yes No
Bite your lips or cheeks regularly? Yes No
Hold foreign items with your teeth? (pencils, pins, nails) Yes No
Mouth breathe while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No
Smoke/chew tobacco? Yes No How Much?_____

Have you ever had:

Orthodontic Treatment? Yes No Oral Surgery? Yes No
Periodontal Treatment? Yes No Mouth Guard? Yes No
Your bite adjusted? Yes No
A serious injury to the mouth or head? Yes No / if yes, please explain_____
_____

Are any of your teeth sensitive to:

Hot or cold? Yes No Sweet? Yes No
Biting or chewing? Yes No
Have you noticed any mouth odors or bad tastes? Yes No
Do you frequently get cold sores, mouth blisters, or other oral lesions? Yes No
Do your gums bleed or hurt? Yes No
Have your parents experienced gum disease or tooth loss? Yes No
Have you noticed any loose teeth or a change in your bite? Yes No
Do you have difficulty chewing on either side of your mouth? Yes No
Does food tend to become caught in between your teeth? Yes No
if yes, where?_____

Have you ever experienced:

Clicking or popping in the jaw? Yes No Jaw Pain? Yes No
Difficulty opening or closing the mouth? Yes No
Headaches, neck aches, or shoulder aches? Yes No
Sore muscles? (shoulder or neck) Yes No
Are you happy with your smile? Yes No
Are you pleased with the color of your teeth? Yes No
Do you feel nervous about having dental treatment? Yes No
If yes, what is your biggest dental concern? _____
Have you experienced an upsetting dental experience? Yes No
If yes, please describe._____