# Patient Medical History

Who is your PRIMARY CARE PHYSICIAN? ______________________________

Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No If yes, please explain: ______________________________

Have you ever had a serious head or neck injury? ❑ Yes ❑ No If yes, please explain: ______________________________

What MEDICATIONS are you currently taking? Please LIST: ______________________________

Do you take, or have you taken, Phen-Fen or Redux? . . . . . . . . . . ❑ Yes ❑ No

Are you on a special diet? . . . . . . . . . . ❑ Yes ❑ No

Do you use tobacco? . . . . . . . . . . ❑ Yes ❑ No

Do you use controlled substances? . . . . . . . . . . ❑ Yes ❑ No

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? . . . . . . . . . . ❑ Yes ❑ No

Are you wearing contact lenses? . . . . . . . . . . ❑ Yes ❑ No

Do you have a persistent cough or throat clearing no associated with known illness (lasting more than 3 weeks)? . . . . . . . . . . ❑ Yes ❑ No

Are you allergic to any of the following? ❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex Rubber ❑ Local Anesthetics ❑ Sulfa Drugs ❑ Other If yes, please explain: ______________________________

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | ❑ Yes ❑ No | Cortisone Medicine | ❑ Yes ❑ No | Hemophilia | ❑ Yes ❑ No | Recent Weight Loss | ❑ Yes ❑ No |
| Alzheimer's Disease | ❑ Yes ❑ No | Diabetes | ❑ Yes ❑ No | Hepatitis A | ❑ Yes ❑ No | Renal Dialysis | ❑ Yes ❑ No |
| Anaphylaxis | ❑ Yes ❑ No | Drug Addiction | ❑ Yes ❑ No | Hepatitis B or C | ❑ Yes ❑ No | Rheumatic Fever | ❑ Yes ❑ No |
| Anemia | ❑ Yes ❑ No | Easily Winded | ❑ Yes ❑ No | Herpes | ❑ Yes ❑ No | Rheumatism | ❑ Yes ❑ No |
| Angina | ❑ Yes ❑ No | Emphysema | ❑ Yes ❑ No | High Blood Pressure | ❑ Yes ❑ No | Scarlet Fever | ❑ Yes ❑ No |
| Arthritis/Gout | ❑ Yes ❑ No | Epilepsy or Seizures | ❑ Yes ❑ No | High Chloresterol | ❑ Yes ❑ No | Shingles | ❑ Yes ❑ No |
| Artificial Heart Valve | ❑ Yes ❑ No | Excessive Bleeding | ❑ Yes ❑ No | Hives or Rash | ❑ Yes ❑ No | Sickle Cell Disease | ❑ Yes ❑ No |
| Artificial Joint | ❑ Yes ❑ No | Excessive Thirst | ❑ Yes ❑ No | Hypoglycemia | ❑ Yes ❑ No | Sinus Trouble | ❑ Yes ❑ No |
| Asthma | ❑ Yes ❑ No | Fainting Spells/Dizziness | ❑ Yes ❑ No | Irregular Heartbeat | ❑ Yes ❑ No | Spina Bifida | ❑ Yes ❑ No |
| Blood Disease | ❑ Yes ❑ No | Frequent Cough | ❑ Yes ❑ No | Kidney Problems | ❑ Yes ❑ No | Stomach/Intestinal Disease | ❑ Yes ❑ No |
| Blood Transfusion | ❑ Yes ❑ No | Frequent Diarrhea | ❑ Yes ❑ No | Leukemia | ❑ Yes ❑ No | Stroke | ❑ Yes ❑ No |
| Breathing Problem | ❑ Yes ❑ No | Frequent Headaches | ❑ Yes ❑ No | Liver Disease | ❑ Yes ❑ No | Swelling of Limbs | ❑ Yes ❑ No |
| Bruise Easily | ❑ Yes ❑ No | Genital Herpes | ❑ Yes ❑ No | Low Blood Pressure | ❑ Yes ❑ No | Thyroid Disease | ❑ Yes ❑ No |
| Cancer | ❑ Yes ❑ No | Glaucoma | ❑ Yes ❑ No | Lung Disease | ❑ Yes ❑ No | Tonsillitis | ❑ Yes ❑ No |
| Chemotherapy | ❑ Yes ❑ No | Hay Fever | ❑ Yes ❑ No | Mitral Valve Prolapse | ❑ Yes ❑ No | Tuberculosis | ❑ Yes ❑ No |
| Chest Pains | ❑ Yes ❑ No | Heart Attack/Failure | ❑ Yes ❑ No | Pain in Jaw Joints | ❑ Yes ❑ No | Tumors or Growths | ❑ Yes ❑ No |
| Cold Sores/Fever Blisters | ❑ Yes ❑ No | Heart Murmur | ❑ Yes ❑ No | Parathyroid Disease | ❑ Yes ❑ No | Ulcers | ❑ Yes ❑ No |
| Congenital Heart Disorder | ❑ Yes ❑ No | Heart Pace Maker | ❑ Yes ❑ No | Psychiatric Care | ❑ Yes ❑ No | Venereal Disease | ❑ Yes ❑ No |
| Convulsions | ❑ Yes ❑ No | Heart Trouble/Disease | ❑ Yes ❑ No | Radiation Treatments | ❑ Yes ❑ No | Yellow Jaundice | ❑ Yes ❑ No |

Have you ever had any serious illness not listed above? ❑ Yes ❑ No If yes, please explain: ______________________________

### Women:

Are you pregnant / trying to get pregnant? . . . . . . . . . . ❑ Yes ❑ No

Are you taking contraceptives? . . . . . . . . . . ❑ Yes ❑ No

Are you nursing? . . . . . . . . . . ❑ Yes ❑ No

# Patient Dental History

Who is your General Dentist? ______________________ Who is your referring Dentist? ______________________

1. Do your gums bleed while brushing or flossing? ❑ Yes ❑ No
2. Are your teeth sensitive to hot or cold liquids/foods? ❑ Yes ❑ No
3. Are your teeth sensitive to sweet or sour liquids/foods? ❑ Yes ❑ No
4. Do you feel pain to any of your teeth? ❑ Yes ❑ No
5. Do you have any sores or lumps in or near your mouth? ❑ Yes ❑ No
6. Have you had any head, neck or jaw injuries? ❑ Yes ❑ No
7. Have you ever experienced any of the following problems in your jaw?
   - Clicking ❑ Yes ❑ No
   - Pain (joint, ear, side of face) ❑ Yes ❑ No
   - Difficulty in opening or closing? ❑ Yes ❑ No
   - Difficulty in chewing ❑ Yes ❑ No
8. Do you have frequent headaches? ❑ Yes ❑ No
9. Do you clench or grind your teeth? ❑ Yes ❑ No
10. Do you bite your lips or cheeks frequently? ❑ Yes ❑ No
11. Have you ever had any difficult extractions in the past? ❑ Yes ❑ No
12. Have you ever had any prolonged bleeding following extractions? ❑ Yes ❑ No
13. Have you had any orthodontic treatment? ❑ Yes ❑ No
14. Do you wear dentures or partials? ❑ Yes ❑ No
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ❑ Yes ❑ No
16. Do you like your smile? ❑ Yes ❑ No

## 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 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. I further understand that I will be responsible for any legal/or collection fees should my account become delinquent.

***Signature of Patient - X*** ______________________________ Date ______________

***Signature of Parent/Guardian*** *(if minor)* ***-X*** ______________________________ Date ______________