

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

- | | | | |
|--|--|--|--|
| <p>1. Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain _____</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain _____</p> <p>3. Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what medication(s) are you taking? _____</p> <p>4. Do you have a history of substance addiction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you had recent Cataract Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you have or have you had any of the following?</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"> <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting / Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy / Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS or HIV Infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problem <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </td> <td style="width: 50%;"> <p>Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiac Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequently Tired <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Replacement or Implant <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis / Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Troubles / Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </td> </tr> </table> | <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting / Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy / Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS or HIV Infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problem <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiac Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequently Tired <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Replacement or Implant <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis / Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Troubles / Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>10. Are you allergic to or have you had any reactions to the following?</p> <p>Local Anesthetics (e.g. Novacain) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin or any other Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sulfa Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Barbiturates <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any Metals (e.g. nickel, mercury, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Latex Rubber <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other (please list) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Do you have a persistent cough or sore throat clearing not associated with a known illness (lasting more than 3 weeks) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Women Only:</p> <p>a) Are you pregnant or think you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Are you taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting / Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy / Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS or HIV Infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problem <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiac Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequently Tired <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Replacement or Implant <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis / Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Troubles / Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | | |

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

- | | |
|--|---|
| <p>1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Do you have any fear of going to the dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Are you interested in sedation dentistry? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please answer the following questions:</p> <p>Do you have narrow angle glaucoma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you use antacids? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you take antifungal medication by mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you take any herbal medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you feel pain to any of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>6. Do you have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you sip sodas or eat candy between meals? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Are you on flouridated water? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Have you had any orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Do you wear dentures or partials? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Do you like your smile: <input type="checkbox"/> Yes <input type="checkbox"/> No
If no, what would you like to change? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Do you snore? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you use a C-PAP machine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|---|

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 authorized 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 and 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 behalf of my dependents.

X _____
Signature of patient (or parent/guardian if minor)

<p>Doctor's Comments _____</p>
<p style="text-align: center;">Signature _____ Date _____</p>