Patient's Name: _____

MEDICAL HISTORY

PATIENT PLEASE COMPLETE

1. When were your teeth cleaned last? _____
2. Are you having pain or discomfort in any of your teeth? ..... ☐YES ☐NO
3. Do you feel nervous about having dental treatment? ..... ☐YES ☐NO
4. Have you ever had a bad experience in a dental office? ..... ☐YES ☐NO
5. Have you been a patient in the hospital during the last two years? ..... ☐YES ☐NO
6. Have you been under the care of a medical doctor during the past two years for other than routine exams, and if so, WHY? ..... ☐YES ☐NO
7. Are you taking any medicine of drugs? (If so, name)..... ☐YES ☐NO
8. Are you allergic to or made sick by penicillin, latex, aspirin, codeine, or any other drugs or medications? Please describe _____ ☐YES ☐NO
9. Have you ever taken Phen Phen or Redux Medicines?..... ☐YES ☐NO
10. Have you ever had any excessive bleeding requiring special treatment? ..... ☐YES ☐NO

_____

11. Do you take or ever taken Biphosphonates(Fosamax, Boniva, Actonel, Aredia, Zometa etc.) for Osteoporosis or any other condition?..... ☐YES ☐NO

*** Please answer YES or NO***

*** REQUIRES PREMEDICATION**

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Artificial Heart Valve*	☐	☐	Stroke	☐	☐	Chemotherapy	☐	☐	Hepatitis A
☐	☐	Heart Murmur*	☐	☐	Kidney Trouble	☐	☐	Liver disease	☐	☐	Hepatitis B
☐	☐	Rheumatic Fever*	☐	☐	Ulcers	☐	☐	Arthritis	☐	☐	HIV
☐	☐	Mitral Valve Prolapse*	☐	☐	Emphysema	☐	☐	Rheumatism	☐	☐	Yellow Jaundice
☐	☐	Artificial Joint*	☐	☐	Tuberculosis	☐	☐	Glaucoma	☐	☐	Blood Transfusion
☐	☐	Congenital Heart Lesions	☐	☐	Asthma	☐	☐	Epilepsy or Seizures	☐	☐	Drug Addiction
☐	☐	Heart Pacemaker	☐	☐	Sinus Trouble	☐	☐	Fainting or Dizzy Spells	☐	☐	Hemophilia
☐	☐	Heart/Bypass Surgery	☐	☐	Allergies	☐	☐	Sickle Cell Disease	☐	☐	Syphilis
☐	☐	Heart Disease/Attack	☐	☐	Diabetes	☐	☐	Psychiatric Treatment	☐	☐	Gonorrhea
☐	☐	Angina Pectoris	☐	☐	Thyroid Disease	☐	☐	Bruise Easily	☐	☐	Cold Sores
☐	☐	High Blood Pressure	☐	☐	Scarlet Fever	☐	☐	Periodontal Disease	☐	☐	Herpes

11. When you walk up stairs, do you ever have to stop because of pain In your chest, or shortness of breath, or because you are very tired?..... YES NO
13. Do your ankles swell during the day?..... YES NO
14. Has your medical doctor ever said you have cancer or a tumor? ..... YES NO
15. Do you have any disease, condition, or problem not listed? If so, name..... YES NO
16. Do you smoke or use tobacco?..... YES NO
17. WOMEN: Are you pregnant now?..... YES NO
    If yes, how many months? _____

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 agre to be responsible for payment of all services rendered on my behalf or my dependents.

_____	_____	_____
Date	**Dr. Signature**	**Signature of Patient, Parent or Guardian**

Date	**Addition**	**Patient Signature**	**Dr. Signature**
_____	_____	_____	_____