Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Have you been ill recently?	☐	☐
2. Are you under the care of a physician now?	☐	☐
If yes, explain _____		
3. Do you have or have you ever had any of the following?		
Rheumatic Fever	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Attack / Heart Disease	☐	☐
Heart Murmur	☐	☐
High Blood Pressure	☐	☐
Mitral Valve Prolapse	☐	☐
Angina	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Fainting Spells / Seizures / Epilepsy	☐	☐
Hepatitis / Jaundice	☐	☐
Cancer / Leukemia / Radiation Therapy	☐	☐
Asthma / Respiratory Problems / Emphysema.	☐	☐
Joint Replacement / Implant / Pacemaker	☐	☐
Sexually Transmitted Disease / VD	☐	☐
AIDS or HIV Infection	☐	☐
Are you pregnant or think you might be?	☐	☐
Are you taking birth control pills?	☐	☐

	Yes	No
4. Are you allergic to or have you had reactions to any of the following?		
Local Anesthetic	☐	☐
Penicillin	☐	☐
Other Medications	☐	☐
If yes, explain _____		
Latex Rubber / Nickel?	☐	☐
5. Are you taking any medication(s) at this time?	☐	☐

If yes, what medication? _____

IT IS ESPECIALLY IMPORTANT FOR US TO KNOW IF YOU ARE TAKING TRANQUILIZERS, PHENOBARBITAL, DILANTIN, ANY MEDICINES TO PREVENT BLOOD CLOTS, ANY OF THE CORTISONE MEDICINES, INSULIN, BLOOD PRESSURE, OR HEART MEDICINE.

If yes to any above, please explain _____

Patient Dental History

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

Purpose of this Appointment _____

	Yes	No
1. Have you ever had any prolonged bleeding following tooth extractions?	☐	☐
2. Have you ever received oral hygiene instructions on care of teeth & gums?	☐	☐
3. 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 perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the above patient and further authorize and consent that the dentist employs such assistance as he deems fit. I also understand that previous to treatment, the dentist and / or his staff will give full explanation of the procedure(s) involved. 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 the third party payors and / or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier my 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.

X _____ Date _____