Patient Medical History

Physician_____ Office Phone_____ Date of last exam_____

Are you under medical treatment now? Y N

Have you been hospitalized for any surgery or serious illness within the last 5 years? Y N

If yes, please explain_____

Are you taking any medications, including non-prescription medicine? Y N If yes, please list:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? Y N

Are you currently taking Coumadin, Plavix, Xarelto or any other blood thinners? Y N

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

High Blood Pressure Y N	Rheumatic Fever Y N	Fainting/Seizures Y N	Respiratory Problems Y N
Asthma Y N	Low Blood Pressure Y N	Epilepsy/Seizures Y N	Diabetes Y N
Kidney Diseases Y N	AIDS/HIV Infection Y N	Thyroid Problem Y N	Angina Y N
Heart Disease Y N	Cardiac Pacemaker Y N	Emphysema Y N	Cancer Y N
Hepatitis/Jaundice Y N	Stroke Y N	Hay Fever/Allergies Y N	Tuberculosis Y N
Liver Disease Y N	Other:_____		

Are you allergic to or have had any reactions to any antibiotics? Please list: _____

_____

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam _____

Do your gums bleed while brushing or flossing? Y N Are your teeth sensitive to hot or cold? Y N

Are your teeth sensitive to sweet or sour liquids/foods? Y N Do you feel pain in any of your teeth? Y N Have you experienced any difficulty in chewing? Y N

Do you have any sores/lumps in or near your mouth? Y N Have you had any head, neck of jaw injuries? Y N

Have you ever experienced any of the following problems in your jaw?

Clicking? Y N Pain (joint, ear, side of face)? Y N Difficulty opening/closing? Y N

Do you clench or grind your teeth? Y N Do you bite your lips or cheeks frequently? Y N

Have you had any difficult extractions in the past? Y N Have you had any orthodontic treatment? Y N

Have you ever had prolonged bleeding following extractions? Y N Do you wear dentures/partials? Y N If so, date of insertion? _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge and that 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 that of my dependents.

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

Doctor or Dental Hygienist's Signature _____ Date _____