Account Number _____ Date _____

Patient Name _____

MEDICAL HISTORY

	Yes	No
Are you having pain or discomfort at this time?	❑	❑
Have you been a patient in the hospital during the past two years?	❑	❑
Have you been under the care of a medical doctor during the past two years?	❑	❑
Are you currently being treated by a physician? If so, why _____		
Physician's Name _____		
Phone No. _____		
Have you taken any medication or drugs during the past two years?	❑	❑
Are you now taking any medication, drugs or pills? If yes, please list:	❑	❑
_____ What for: _____		
_____ What for: _____		

Are you aware of being allergic to or have you ever reacted adversely to any of the following medication or substance? Please circle if yes:

Penicillin	Codeine	Latex
Erythromycin	Aspirin	Local Anesthetic (Novocaine)
Sulfa	Nickel	Any other, please list: _____

	Yes	No
When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?	❑	❑
Do your ankles swell during the day?	❑	❑
Do you use more than two pillows to sleep?	❑	❑
Have you lost or gained more than 10 pounds in the past year?	❑	❑
Do you ever wake up from sleep and feel short of breath?	❑	❑
Are you on a special diet?	❑	❑

FOR WOMEN ONLY:

Are you pregnant? If yes, what month? _____	❑	❑
Are you nursing?	❑	❑
Are you taking birth control pills?	❑	❑

Do you have or have you been treated for: (Please check Yes or No)

	Yes	No
Any Heart	❑	❑
Heart failure	❑	❑
Stroke	❑	❑
Heart Disease or Attack	❑	❑
Angina Pectoris	❑	❑
Congenital Heart Disease	❑	❑
Heart Valve Defect	❑	❑
Heart Murmur	❑	❑
High Blood Pressure	❑	❑
Low Blood Pressure	❑	❑
Arteriosclerosis	❑	❑
Mitral Valve Prolapse	❑	❑
Artificial Heart Valve	❑	❑
Heart Pacemaker	❑	❑
Heart Surgery /By-Pass	❑	❑
Bacterial Endocarditis	❑	❑
Rheumatic Fever	❑	❑
Artificial Joints (hip, knee etc)	❑	❑
Tuberculosis	❑	❑
Emphysema	❑	❑
Chronic Cough	❑	❑
Do you Smoke	❑	❑
Asthma	❑	❑

	Yes	No
Bronchitis	❑	❑
Hay Fever	❑	❑
Allergies or Hives	❑	❑
Sinus Trouble	❑	❑
Lung / Breathing Problems	❑	❑
Radiation Therapy	❑	❑
Chemotherapy	❑	❑
Cancer/Tumor/Other Growths	❑	❑
Hepatitis - A, B, or C (please circle)	❑	❑
Venereal Disease	❑	❑
A.I.D.S	❑	❑
H.I.V. Positive	❑	❑
Sexually Transmitted Diseases	❑	❑
Other Infectious Diseases	❑	❑
Blood Transfusion	❑	❑
Hemophilia	❑	❑
Anemia	❑	❑
Sickle Cell Disease	❑	❑
Bruise Easily	❑	❑
Difficulty Healing	❑	❑
Any Bleeding Disorders	❑	❑
Adrenal / Pituitary Problems	❑	❑

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Account Number _____ Date _____

Patient Name _____

	Yes	No		Yes	No
Arthritis	❑	❑	**Liver Disease**	❑	❑
Cortisone Medicine	❑	❑	Yellow Jaundice	❑	❑
Ulcers/Stomach Problems	❑	❑	**Epilepsy or Seizures**	❑	❑
Diabetes	❑	❑	Fainting or Dizzy Spells	❑	❑
Thyroid Problems	❑	❑	**Alcoholism**	❑	❑
Glaucoma	❑	❑	Drug Addiction	❑	❑
Cosmetic Surgery	❑	❑	**Nervousness / Mental Disorder**	❑	❑
Cold Sores/Fever Blisters	❑	❑	Psychiatric Treatment	❑	❑
Kidney Trouble	❑	❑	**Developmentally Disabled**	❑	❑

Do you have or have you had any disease, condition, or problem not listed above? ❑ ❑
If yes, please list:

_____ _____

Do you need to take antibiotic pre-medications prior to dental appointments? ❑ ❑
Name of antibiotic: _____

DENTAL HISTORY

	Yes	No
What is the reason for this appointment?_____		
Name of your previous dentist:		
_____		
Reason for leaving your previous dentist: _____		
Do you have any dental records from your previous dentist?	❑	❑
When was your last visit to the dentist? _____ Last cleaning? _____		
What was done at that time? _____		
Are you satisfied with the appearance of your teeth?	❑	❑
If not, please explain: _____		
How would you describe you dental health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor		
Have you noticed a change in the position of any of your teeth?	❑	❑
Do your gums bleed? If so, when? _____		
Are any of your teeth loose?	❑	❑
Do you have pain or soreness in teeth or gums?	❑	❑
Are your teeth sensitive to sweets?	❑	❑
Do you notice "popping" or "clicking" or pain in your jaw?	❑	❑
Do you clench or grind your teeth?	❑	❑
Have you had any teeth removed?	❑	❑
Have you had orthodontic treatment?	❑	❑
Have you had periodontal treatment?	❑	❑
Are you wearing any removable dentures?	❑	❑
List any dental conditions of which you are aware that have not been mentioned:		
_____		

Patient Insurance Consent

- I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
- I authorize the Dentist (s) or designated staff treating me to perform diagnostic procedures deemed appropriate to make a thorough diagnosis of my oral health. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures including administering medications as prescribed by the Dentist (s) and mutually agreed upon by me.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 30 days from the date of treatment will be assessed a late charge per month and if payment is not received within 90 days, I agree to pay any additional charges associated with collections.

Signature of Patient or
Parent/Guardian if Patient is a minor _____ Date _____

Signature of Doctor _____ Date _____