MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Address _____
Street City State Zip

Phone #: (___) _____ Date of Last Visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Are you allergic to any of the following:

Y N	Aspirin	Y N	Erythromycin	Y N	Sedatives
Y N	Barbiturates	Y N	Jewelry	Y N	Sulfa Drugs
Y N	Codeine	Y N	Latex	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Penicillin	Y N	Other

Please list additional drugs/materials that cause allergic reactions: _____

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Unsure Yes No

Week #: _____ Are you nursing? Yes No

Are you taking any of the following

Y N	Acetaminophen	Y N	Blood Thinners	Y N	Insulin/Diabetes Drugs	Y N	Thyroid Medicine
Y N	Antibiotics	Y N	Blood Pressure Medication	Y N	Nitroglycerin	Y N	Tranquilizers
Y N	Antihistamines	Y N	Cold Remedies	Y N	Recreational Drugs	Y N	Fen-Phen
Y N	Aspirin	Y N	Digitalis/Heart Medication	Y N	Steroids/Cortisone		

Are you taking any prescription/over the counter drugs not listed above? Yes No If yes, please list each one: _____

Do you or have you experienced the following?

Y N	Abnormal Bleeding	Y N	Colitis	Y N	Headaches	Y N	Liver Disease	Y N	Shingles
Y N	Alcohol Abuse	Y N	Congenital Heart Defect	Y N	Heart Attack	Y N	Low Blood Pressure	Y N	Sickle Cell Disease
Y N	Anemia	Y N	Diabetes	Y N	Heart Murmur	Y N	Lupus	Y N	Sinus Problems
Y N	Arthritis	Y N	Difficulty Breathing	Y N	Heart Surgery	Y N	Mitral Valve Prolapse	Y N	Stroke
Y N	Artificial Bones/Joints	Y N	Drug Abuse	Y N	Hemophilia	Y N	Pacemaker	Y N	Thyroid Problems
Y N	Artificial Valves	Y N	Emphysema	Y N	Hepatitis	Y N	Persistent Cough	Y N	Tonsillitis
Y N	Asthma	Y N	Epilepsy	Y N	Herpes	Y N	Psychiatric Problems	Y N	Tuberculosis (TB)
Y N	Blood Transfusion	Y N	Fainting Spells	Y N	High Blood Pressure	Y N	Radiation Treatment	Y N	Ulcers
Y N	Cancer	Y N	Fever Blisters	Y N	HIV/AIDS	Y N	Rheumatic Fever	Y N	Venereal Disease
Y N	Chemotherapy	Y N	Glaucoma	Y N	Hospitalized for any reason	Y N	Scarlet Fever		
Y N	Chicken Pox	Y N	Hay Fever	Y N	Kidney Problems	Y N	Seizures		

Please list any serious medical condition(s) that you have experienced: _____

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Are you currently in pain? Yes No

Do you require antibiotics before dental treatment? Yes No

Have you experienced problems associated with any previous dental work Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMI / TMD)? Yes No

Your current dental health is Good Fair Poor

Do you floss daily? Yes No Brush daily? Yes No

Type of bristles on your toothbrush? Hard Medium Soft

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss? Yes No

If yes, what?

Would you like fresher breath? Yes No Whiter teeth? Yes No

Do your gums bleed? Yes No Ever itch? Yes No

Have you ever had periodontal disease? Yes No

Do you have mobility in your teeth? Yes No

Are your teeth sensitive to heat, cold or anything else? _____

Do you still have wisdom teeth? Yes No

If yes, why? _____

Previous/Present Dentist: _____ Last Visit Date: _____
(Please Circle)

Why did you leave your previous dentist? _____

What did you like most & least about any dentist you have seen? _____

_____

Are you happy with the way your smile looks? Yes No

If not, what would you change? _____

_____

AUTHORIZATIONS

I understand the above information is necessary to provide me with dental care in a safe and efficient manner .I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____

PatientSignature_____Date_____

PATIENT HISTORY REVIEWED BY DOCTOR

Doctor Signature_____Date_____

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. _____ of insurance benefits otherwise payable to me. I understand that I am responsible for payment on services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature Date

PAYMENT IS DUE AT THE TIME OF SERVICE