

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of last Exam _____

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| <p>1. Are you under medical treatment now? Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>2. Have you been hospitalized for any surgical operation in the last five years? Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p style="margin-left: 20px;">If yes, please explain _____
 _____</p> <p>3. Are you taking any medication(s) including non-prescription medicine? Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p style="margin-left: 20px;">If yes, what medication(s) are you taking? _____
 _____</p> <p>4. Do you use tobacco? Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>5. Do you use controlled substances? Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>6. Are you wearing contact lenses? Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> | <p>7. Women Only: Men continue to question 8</p> | <p>Are you pregnant or think you may be pregnant? Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you nursing? Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you taking oral contraceptives? Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>8. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p>9. Are you allergic to or have you had any reactions to:</p> <p style="margin-left: 20px;">Local anesthetics (e.g. Novocain) Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p style="margin-left: 20px;">Penicillin or any other Antibiotics Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p style="margin-left: 20px;">Sulfa Drugs Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p style="margin-left: 20px;">Barbiturates Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p style="margin-left: 20px;">Sedatives Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p style="margin-left: 20px;">Iodine Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p style="margin-left: 20px;">Aspirin Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p style="margin-left: 20px;">Any metals (e.g. Nickel, Mercury, etc.) Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p style="margin-left: 20px;">Latex Rubber Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> <p style="margin-left: 20px;">Other _____ Yes No
 <input type="checkbox"/> <input type="checkbox"/></p> |
|--|--|--|

10. Do you have or have you had any of the following? (Please complete all columns.)

- | | | | | | | | | |
|-----------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No | | Yes | No |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement or Implant | <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV infection | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles/Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Dental History

Name of Previous Dentist _____ Date of last Exam _____

Previous Dentist's Location _____ Date of last Cleaning _____

- | | |
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| <p>Do your gums bleed while brushing or flossing? Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Are your teeth sensitive to hot or cold liquids/foods? Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you feel pain to any of your teeth? Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you have any sores/lumps in or near your mouth? Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Have you had any head, neck or jaw injuries? Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Have you ever experienced any of the following problems in you jaw? Yes no</p> <p style="margin-left: 20px;">Clicking Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> <p style="margin-left: 20px;">Pain (joint, ear, side of face) Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> <p style="margin-left: 20px;">Difficulty in opening or closing Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> <p style="margin-left: 20px;">Difficulty in chewing Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> | <p>Do you have frequent headaches? Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you clench or grind your teeth? Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you bite your lips or cheeks frequently? Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Have you had difficult extractions in the past? Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Have you ever had any prolonged bleeding following extractions? Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Have you had any orthodontic treatment? Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you wear dentures or partials? Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> <p style="margin-left: 20px;">if Yes, date of placement _____</p> <p>Have you ever received oral hygiene instruction regarding the care of your teeth and gums? Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you like your smile? Yes no
 <input type="checkbox"/> <input type="checkbox"/></p> |
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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 diagnosis and the records of any treatment or examination rendered to me or to my child during the period of such dental care to third party payers 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 my dependents. Unpaid balances are charged interest at the rate of 18% annually. I understand that there may be a fee charged for appointments canceled without proper notice.

Signature _____ Date _____