

Your current physical health is: Good Fair Poor

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

Have you had any metal rods, pins or implants? Yes No

Are you taking any prescription / over-the-counter or herbal supplement drugs? Yes No

Please list each one: _____

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) Yes No
If so, when? _____

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

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes / Fever Blisters |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol / Drug Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus |
| <input type="checkbox"/> Y <input type="checkbox"/> N Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | |

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

Are you allergic to any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Other |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin | |

Please list any other drugs/materials that you are allergic to: _____

Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Have you ever had gum treatment? Yes No

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

Your current dental health is Good Fair Poor

Do you like your smile? Y N Do your gums ever bleed? Y N

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? Soft Medium Hard

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

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

Have you lost any teeth? Yes No If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____

Date _____

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____

Date _____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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I verbally reviewed the medical / dental information above with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____

Signature _____ Date _____

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____

Signature _____ Date _____

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____

Signature _____ Date _____