

PATIENT MEDICAL HISTORY

WHO IS YOUR MEDICAL DOCTOR? _____ PHONE _____ LAST EXAM _____

ARE YOU ALLERGIC TO OR MADE SICK BY ANY OF THE FOLLOWING:

- PENICILLIN CODEINE LATEX SULFA ASPIRIN NOVOCAINE TETRACYCLINE
 OTHER DRUG OR MATERIAL _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE BIRTH CONTROL)

WOMEN, ARE YOU:

PREGNANT/TRYING TO GET PREGNANT? YES NO TAKING ORAL CONTRACEPTIVES? YES NO NURSING? YES NO

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No | Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells/Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No | Genital Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Failure <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble/Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No |

PATIENT DENTAL HISTORY

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU.

- Sensitivity (hot, cold, sweet)
- Where? Upper Right Lower Right Upper Left Lower Left
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

- Dentures
- Partial Dentures
- Braces
- Gum Treatments

PLEASE SHARE THE FOLLOWING DATES:

- Your Last Cleaning ____ / ____
- Your last oral cancer screening ____ / ____
- Your last complete X-Rays ____ / ____

NAME OF PREVIOUS DENTIST _____

CITY _____ STATE _____

PHONE NUMBER _____

WHAT IS THE MOST IMPORTANT THING TO YOU ABOUT YOUR FUTURE SMILE AND DENTAL HEALTH?

IF YOU COULD WHITEN YOUR TEETH FOR A COST ANYONE COULD AFFORD, WOULD YOU DO IT?

DO YOU SMOKE OR USE CHEWING TOBACCO?

How Much? _____ For how Long? _____

IF I COULD CHANGE MY SMILE, I WOULD:

- Make them whiter
- Make the straighter
- Close spaces
- Replace black metal fillings with tooth colored restorations
- Repair chipped teeth
- replace missing teeth
- replace old crowns that don't match
- Have a smile makeover

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

WHY DID YOU LEAVE YOUR PREVIOUS DENTIST?

WHAT IS THE MOST IMPORTANT THING TO YOU ABOUT YOUR DENTAL VISIT TODAY?

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 the diagnosis and the records of any treatment or examination rendered to me 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. I further agree that if I fail to promptly pay such amounts when due, I will be responsible for all resulting costs, expenses and legal fees.

SIGNATURE OF PATIENT _____

DATE _____

06/12