PATIENT NAME_____DATE_____

MEDICAL/DENTAL HISTORY

Previous dentist and date of last dental exam/x-rays/cleaning:

_____

Do you like the appearance of your teeth? Yes/No
Are you having pain or discomfort at this time? Yes/No
Are your teeth sensitive to hot or cold or sweets? Yes/No
Do your gums bleed while brushing or flossing? Yes/No
Have you experienced any of the following problems in your jaw? Clicking? Pain (joint, ear, side of face), Difficulty in chewing, opening or closing? Yes/No
Do you have frequent headaches? Yes/No
Do you clench or grind your teeth? Yes/No
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain Yes/No
Are you under medical treatment now? Yes/No
Are you taking any medication(s) including non-prescription medicine? If yes, list below: Yes/No

RX:

Do you Snore? Or have sleep apnea? Yes/No

Do you take or have you ever taken medications for osteoporosis, including Actonel, Boniva, Didronel, Fosamax, Skelid, (risedronate, ibandronate, etidronate, alendronate, tiludronate)? Yes/No
Have you ever received I.V. Aredia, Bonefos, Zometa (pamidronate, Clodronate, Zolendronic acid) Yes/No
Have you ever had radiation to head and neck? Yes/No
History of prolonged bleeding following Extractions? Yes/No
Do you use tobacco? Yes/No
Do you use controlled substances? Yes/No
Are you allergic to or have you had any reactions to the following? Please circle Yes/No
Local Anesthetics, Penicillin or any other Antibiotics, Clindamycin, Codeine, Tylenol, Barbiturates, Any Metals (e.g. nickel, copper.), Latex, Other (please list) _____
Have you ever taken Phen-Fen or similar diet drugs? Yes/No
Are you pregnant or think you may be pregnant? Yes/No
Are you nursing? Yes/No
Are you taking oral contraceptives? Yes/No
Is there anything about being here for treatment that bothers you?

Have you had a previous negative experience in an office/clinic before?

Have you previously required special procedures or medication for nervousness before an appointment?

Physician _____Office phone _____Date of last exam _____

Do you or have you had any of the following?

Allergies (to medicines)	Yes/No	Artificial joints	Yes/No	Cancer	Yes/No
High Blood Pressure	Yes/No	Drug addiction	Yes/No	Chemotherapy	Yes/No
Infective Endocarditis	Yes/No	Epilepsy/Convulsions	Yes/No	Arthritis	Yes/No
Artificial heart valve	Yes/No	Diabetes	Yes/No	Venereal Disease	Yes/No
Congenital heart disorder	Yes/No	Kidney disease	Yes/No	Stomach Ulcers	Yes/No
Heart attack or disease	Yes/No	Hepatitis A, B, or C	Yes/No	Stroke	Yes/No
Heart surgery	Yes/No	AIDS	Yes/No	Hay Fever / Allergies	Yes/No
Angina/chest pain	Yes/No	HIV positive	Yes/No	Tuberculosis	Yes/No
Irregular heart beat	Yes/No	Thyroid problem	Yes/No	Radiation Therapy	Yes/No
Cardiac Pacemaker/stent	Yes/No	Leukemia		Glaucoma	Yes/No
Fainting/seizures	Yes/No		Yes/No	Recent Weight Loss	Yes/No
Anemia	Yes/No	Bruise easily	Yes/No	Liver Disease	Yes/No
Asthma	Yes/No	Excessive bleeding	Yes/No	Other, if yes, list	Yes/No
Psychiatric care	Yes/No	Emphysema	Yes/No		

Authorization and Release

1. 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 or 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 agree to be responsible for payment of all services rendered on my behalf or my dependents.
2. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's deemed needs and to administer medications necessary for my dental care.
3. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
4. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. I understand that my dental insurance carrier may pay less than the actual bill for services. In the event payments are not received by the agreed upon dates, I understand that a 1 ½ % finance charge (21% APR) may be added to my account, in addition to any collection charges and/or attorney fees.
5. I understand that where appropriate, credit bureau reports may be obtained.
6. I understand that it is my responsibility to advise your office of any changes in the information contained in this form

X_____ Reviewed by Dr._____

Signature of patient (or parent if minor)