Medical History

Name_____ Date_____

Whom may we thank for referring you to our office?_____

Physician_____ Office Phone_____

Date of Last Exam_____ Are you under treatment now? Yes No

Have you been hospitalized for any surgical operation or serious illness within the last 5 years?..... Yes No

Are you taking any medications?..... Yes No

Please list medications_____

_____

Do you use tobacco products?..... Yes No

_____

Do you use controlled substances?..... Yes No

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Women Only: Are you pregnant or think you may be pregnant? Yes No
Are you nursing?..... Yes No
Are you taking oral contraceptives?..... Yes No

Previous Dentist_____ Date of Last Exam_____

	YES	NO	
Do your gums bleed while brushing or flossing?.....	YES	NO	_____
Do you have frequent headaches?.....	YES	NO	_____
Are you teeth sensitive to hot or cold?.....	YES	NO	_____
Do you clench or grind your teeth?.....	YES	NO	_____
Do you have pain in any teeth?.....	YES	NO	_____
Have you had prolonged bleeding following extractions or any other dental procedure?.....	YES	NO	_____
Do you have any sores or lumps in or around your mouth?.....	YES	NO	_____
Have you experienced any jaw problems?.....	YES	NO	_____
Have you had any head or neck injuries?.....	YES	NO	_____

Payment is due at the time of treatment. This office accepts insurance and will submit your treatment ot your insurance company. I understand that I am responsible for payment services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I understand that the information I have given today is correct to 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.

Signature of Patient or Guardian_____ Date_____

Are you allergic to or had a reaction to any of the following?

	Yes	No		Yes	No
Local anesthetic (Novocain)	Y	N	Penicillin/Antibiotics	Y	N
Sulfa Drugs	Y	N	Barbiturates	Y	N
Sedatives	Y	N	Iodine	Y	N
Aspirin	Y	N	Metals (nickel, mercury, etc.)	Y	N
Latex Rubber	Y	N	Other	Y	N

Do you have a persistent cough not associated with an illness for more than 3 weeks? Y N

Do you have any of the following?

	Yes	No
High Blood Pressure	□	□
Cancer	□	□
Low Blood Pressure	□	□
Arthritis	□	□
Heart Attack	□	□
Joint Replacement/Implant	□	□
Rheumatic Fever	□	□
Hepatitis/ Jaundice	□	□
Swollen Ankles	□	□
Sexually Transmitted Disease	□	□
Fainting/ Seizures	□	□
Stomach Troubles/Ulcers	□	□
Asthma	□	□
Chest Pains	□	□
Epilepsy/Convulsions	□	□
Stroke	□	□
Leukemia	□	□
Hay Fever/Allergies	□	□
Diabetes	□	□
Tuberculosis	□	□
Kidney Disease	□	□
Radiation Therapy	□	□
AIDS or HIV Infection	□	□
Glaucoma	□	□
Thyroid Problem	□	□
Recent Weight Loss	□	□
Heart Disease Cardiac Pacemaker	□	□
Liver Disease	□	□
Heart Murmur	□	□
Heart Trouble	□	□
Angina	□	□
Respiratory Problems	□	□
Frequently Tired	□	□
Mitral Valve Prolapse	□	□
***Any need to premedicate prior to dental appointments*?**	□	□
Emphysema	□	□
Other	□	□

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