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

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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____

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

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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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