PATIENT MEDICAL HISTORY Physician: _ _ _ Office Phone: _ Date of Last Exam:_ Yes No Yes No 10. Are you wearing contacts? 1. Are you under medical treatment now? 11. Are you allergic to or have you had any reactions to 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain the following? Local Anesthetics (e.g. Novocain) Penicillin or any other Antibiotics Sulfa Drugs 3. Are you taking any medication(s) including non-prescription **Barbiturates** medicine? If yes, What medication(s) are you taking? _ _ _ _ Sedatives Iodine Aspirin 4. Have you ever taken Fen-Phen/Redux? Any Metals (e.g. nickel, mercury, etc.) Latex Rubber 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphospho nates? Other (please list)______ 6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 12. Do you have a persistent cough or throat clearing not 24 hours? associated with a known illness? (Lasting more than 3 weeks) 7. Do you use tobacco? 13. Women Only: a) Are you pregnant or think you may be pregnant? 8. Do you use controlled substances? b) Are you nursing? 9.Do you have or have you had any of the following? c) Are you taking oral contraceptives? Yes No. Yes No Yes No High Blood Pressure **Heart Disease Chest Pains Heart Attack** Cardiac Pacemaker Easily Winded Rheumatic Fever Heart Murmur Stroke Swollen Ankles Angina Hay Fever/Allergies Fainting/Seizures Frequently Tired **Tuberculosis** Asthma Anemia **Radiation Therapy** Low Blood Pressure Emphysema Glaucoma Epilepsy/Convulsions Recent Weight Loss Cancer Leukemia Arthritis Liver Disease Diabetes Heart Trouble Joint Replacement or Implant **Kidney Diseases** Hepatitis/Jaundice **Respiratory Problems** AIDS or HIV Infection Sexually Transmitted Disease Mitral Valve Prolapse Thyroid Problem Stomach Troubles/Ulcers Other_ _ _ _ PATIENT DENTAL HISTORY Name of Previous Dentist and Location____ _ _ _ Date of Last Exam_ Yes No Yes No 1. Do your gums bleed while brushing or flossing? 8. Do you have frequent headaches? 2. Are your teeth sensitive to hot or cold liquids/foods? 9. Do you clench or grind your teeth? 3. Are your teeth sensitive to sweet or sour liquids/foods? 10. Do you bite your lips or cheeks frequently? 4. Do you feel pain to any of your teeth? 11. Have you ever had any difficult extractions in the past? 12. Have you ever had any prolonged bleeding 5. Do you have any sores or lumps in or near your mouth? following extractions? 6. Have you had any head, neck, or jaw injuries? 13. Have you had any orthodontic treatments? 7. Have you ever experienced any of the following problems in your jaw? 14. Do you wear dentures or partials? Clicking 15. Have you ever received oral hygiene instructions Pain (joint, ear, side of face) regarding the care of your teeth and gums? Difficulty in opening or closing 16. Do you like your smile? Difficulty in chewing AUTHORIZATION AND RELEASE 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 payors 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 or my dependents. Signature of patient (or parent/guardian if minor) Date I agree to an e-signature Doctor's Comments _ _ _ _ _____Signature__