

DENTAL HISTORY

- 1) How LONG SINCE you have seen a dentist? _____
- 2) Last COMPLETE dental exam? _____
- 3) Last FULL MOUTH X-RAYS (16 small films or panoramic), Date _____
- 4) How is your current DENTAL health? _____
- 5) Have you ever been told that you have GUM DISEASE Yes No
- 6) Do your gums BLEED, or feel TENDER or IRRITATED? Yes No
- 7) Are you UNHAPPY with the APPEARANCE of you teeth? Yes No
- 8) Do you use tobacco products? Yes No What Type? _____
- 9) Are you currently having any DENTAL problems? Yes No

MEDICAL HISTORY

- 1) Do you have a family physician? Yes No Name _____
- 2) Have you been hospitalized in the past 5 years? Yes No
- 3) Are you receiving medical treatment now? Yes No
- 4) Are you currently taking any drugs or medications? Yes No

If yes, please list _____

- 5) Have you ever had bleeding problems after a cut or tooth extraction? Yes No
- 6) Women: Are you pregnant? Yes No Due Date _____
 Are you nursing? Yes No
 Are you taking birth control pills? Yes No
- 7) Do you have or have you ever had:

- | | | | | | | |
|--------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|------------------------|
| | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart attack | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joints* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart failure | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Angina Pectoris | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A or B |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever* | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur* | <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse* | <input type="checkbox"/> | <input type="checkbox"/> | Drug/Alcohol Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve* | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | A.I.D.S./HIV+ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Intestinal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fainting/Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis (TB) | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease |
| | | | | <input type="checkbox"/> | <input type="checkbox"/> | Radiation/Chemotherapy |

*If yes to any of the asterisked conditions, please call prior to your appointment as premedication may be required.

- 8) Have you ever had an adverse reaction to any of the following: (Check Y or N)

- | | | | | | | |
|--------------------------|--------------------------|--------------------------|-----------|--------------------------|--------------------------|-------------|
| | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> | Percodan |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Darvon | <input type="checkbox"/> | <input type="checkbox"/> | Codeine |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Novacaine | <input type="checkbox"/> | <input type="checkbox"/> | Valium |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Latex | <input type="checkbox"/> | <input type="checkbox"/> | Nickel |
| | | | | | | Other _____ |

- 9) Is there any other medical information we should know about? _____

I understand that the information I have given today is correct to the best of 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 in my medical status.

Patient Signature (Parent or Guardian) _____ Date _____

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

MEDICAL HISTORY