

## Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes Please explain: \_\_\_\_\_  
 Have you ever been hospitalized or had a major operation?  Yes Please explain: \_\_\_\_\_  
 Have you ever had a serious head or neck injury?  Yes Please explain: \_\_\_\_\_  
 Do you use tobacco?  Yes \_\_\_\_\_  
 Have you taken Fosamax, Aredia, Actonel, Boniva or Zometa for osteoporosis or cancer therapy?  Yes \_\_\_\_\_

Women: Are you  Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following? \_\_\_\_\_

- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Jewelry  
 Other If yes, please explain: \_\_\_\_\_

Do you have or have you had any of the following? \_\_\_\_\_

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive      | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Alzheimer's Disease    | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Yellow Jaundice            |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Mitral Valve Prolapse |   |
| <input type="checkbox"/> Breathing Problem      | <input type="checkbox"/> Heart Attack/Failure      | <input type="checkbox"/> Osteoporosis          |   |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Radiation Treatments  |   |
| <input type="checkbox"/> Chest Pains            | <input type="checkbox"/> Heart Pacemaker           | <input type="checkbox"/> Recent Weight Loss    |   |

Have you ever had any serious illness not listed above?  Yes Please explain: \_\_\_\_\_

List any medications you are taking (including non prescription medications): \_\_\_\_\_

## Dental History

Do your gums bleed while brushing or flossing?  Yes  No

Are your teeth sensitive to sweets or temperature?  Yes  No

Have you experienced pain or difficulty opening/closing your jaw?  Yes  No

Are you happy with your smile and the appearance of your teeth?  Yes  No

Do you grind or clench your teeth?  Yes  No

When was your last dental visit? \_\_\_\_\_

## Authorization, Consent and Release

Consent: I give my consent to the doctor and staff to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. 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.

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. It is my responsibility to inform the dental office of any changes in medical status. I authorize the dentist to release any information including the diagnosis and

the records of any treatment or examinations 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.

  X   \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of patients (or parent/guardian of minor)