

Patient Name: _____ Phone # _____ Birth date: _____

Former Dentist _____ Date of last visit: _____

Physician's name: _____ Date of last visit: _____

Are you required to pre-medicate before a dental appointment? __yes __no; If yes why? _____

Have you taken Phen-Fen or Redux? __yes __no Do you use tobacco? __yes __no

Are you pregnant or nursing? __yes __no Taking oral contraceptives? __yes __no, If yes what? _____

Mark (X) if you have had any of the following?

__ Bad breath __ Bleeding gums __ Clicking or popping jaw __ Food collection between the teeth
__ Grinding teeth __ Loose teeth or broken fillings __ Periodontal treatment __ Sensitivity to cold
__ Sensitivity to hot __ Sensitivity to sweets __ Sensitivity when biting __ Sores or growths in mouth

Do you have, or have you had any of the following?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone treatment | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Sickle Cell disease |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Artificial joints, pins | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stomach disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Swelling of limbs |
| <input type="checkbox"/> Bleeding abnormally | <input type="checkbox"/> Headaches | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Heart pace maker | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Ulcer / Colitis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Rapid weight gain or loss | |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Respiratory disease | |
| <input type="checkbox"/> Congenital heart lesion | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatism | |

Have you had any other condition/ illness /operation? When/Describe: _____

List medications you are currently taking: _____

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Allergies: _____

Authorization and Release:

To the best of my knowledge, the questions on this form 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 doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I authorize the use of this signature on all insurance submissions.

Signature of patient, parent or guardian _____ Date _____