DENTAL AND MEDICAL HISTORY

PATIENT NAME: ____

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.

IF YOU ANSWER "*YES*" TO ANY QUESTION, PLEASE EXPLAIN

Are you under a physician's care now? O Yes O No ______________________________

Have you ever been hospitalized or had a major operation? O Yes O No ______________________________

Have you ever had a serious head or neck injury? O Yes O No ______________________________

Are you taking any medications, pills, or drugs? O Yes O No ______________________________

(Please include any herbal supplements or diet pills.) ______________________________

Are you on a special diet? O Yes O No ______________________________

Do you use tobacco? O Yes O No Do you use controlled substances? O Yes O No

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

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O Other ______________________________

Do you need pre-medication due to heart murmur, rheumatic heart disease, valve replacement, or joint replacement? O Yes O No

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

- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve*
- ❑ Artificial Joint*
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problem
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack/Failure
- ❑ Heart Murmur*
- ❑ Heart Pace Maker*
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse*
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever*
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

Have you ever had any serious illness not listed above? O **Yes** O **No** **If yes, please explain below:**

Comments: ____

Do you have any specific dental concerns or problems? O Yes O No

Do you have dental exams on a regular basis? O Yes O No

Is your dental health excellent / good / fair / poor? O Yes O No

Do you think you have active decay or gum disease? O Yes O No

Do your gums ever bleed? O Yes O No O Sometimes

How many times per day do you brush? _______ Floss? _____

Have you ever had a scaling/deep cleaning? O Yes O No

Do you feel nervous about having dental treatment? O Yes O No

Have you ever had a bad experience in a dental office? O Yes O No

Do you want to keep your remaining teeth? O Yes O No

Do you like your smile? O Yes O No

Are you interested in brighter or whiter teeth? O Yes O No

AUTHORIZATION AND RELEASE

I certify that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I consent to examination by a dental provider. I understand that if treatment is recommended I will have the opportunity to ask questions before accepting or refusing treatment. 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 allow a photocopy or my signature to be used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by me in writing. 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, and I further understand that fees are due and payable upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

____ ______________________

SIGNATURE OF PATIENT/PARENT/GUARDIAN DATE