MEDICAL HISTORY

Physician____Date of Last Visit_________________________

Address____Phone _________________________________

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication?
What medication(s)? ____
Yes No Are you allergic to any medication? ____
Yes No Do you have a history of a major illness? ____
Yes No Have you had any operations? ____
Yes No Have you ever been involved in a serious accident?_____________________________________
Yes No Have seen a physician in the last 12 months? Why? ____________________________________

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Herpes	Radiation/Chemotherapy
Anemia	Dizziness	High Blood Pressure	Rheumatic Fever
Arthritis	Epilepsy	HIV / Aids	Screws/Pins/Plates
Artificial Joints	Gastrointestinal Disorders	Kidney problems	Shunt
Asthma or Hayfever	Heart Problems	Nervous Disorders	Thyroid Disease
Bone Disorders	Heart Murmur	Pneumonia	Tuberculosis
Congenital Heart Defect	Hepatitis/Liver problems	Prolonged Bleeding	Tobacco Use
Tumor or Cancer			

Are there any medical conditions we have not discussed that you feel we should be aware of? __________________
____

DENTAL HISTORY

Date of last visit ____________________ Name of Previous Dentist_________________________________

What concerns you most about your teeth? ____

Yes No Do you wish to discuss any cosmetic concerns you may have regarding your smile? _______________
Yes No Do you have any concerns regarding chipped or cracked teeth? ___________________________
Yes No Do you have any concerns regarding the alignment or color of your teeth? ______________________
Yes No Have you ever experienced any unfavorable reaction to dentistry? __________________________
Yes No Have you ever lost or chipped any teeth? ____
Yes No Have there been any injuries to face, mouth, or teeth?___________________________________
Yes No Is any part of your mouth sensitive to temperature? Where? ______________________________
Yes No Is any part of your mouth sensitive to pressure? Where? _________________________________
Yes No Do your gums bleed when you brush? ____
Yes No Do you have any type of thumb or tongue habit? _______________________________________
Yes No Are you a mouth breather? ____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? ________________
Yes No Are you aware of your jaw clicking or popping? _______________________________________
Yes No Are you aware of clenching your teeth during the day?_________________________________
Yes No Have you ever been told that you grind your teeth? ____________________________________
Yes No Do you have "tension" headaches?____
Yes No Have you ever experienced chronic ringing in your ears?_________________________________
Female Patients only:
Yes No Are you pregnant? ____

STATEMENT OF ACKNOWLEDGMENT

The success of dental treatment is dependent on many factors, including the severity of the disease, the patient's general physical status, and the willingness to perform proper oral hygiene on a regular basis. As with the treatment of any disease, no cure can be guaranteed. Treatment of any condition, especially when medication and surgical procedures are used, can result in unexpected problems. Such problems can include hemorrhage, prolonged numbness in the treated area, local or systematic reactions to medication (including local anesthetic), teeth which are sensitive to hot, cold or pressure, pulpal damage or tooth loss.

We will make every effort to keep you informed of the treatment outlined for you. Also feel free to ask questions. Your involvement and understanding are very important in the long term success of your treatment.

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and Staff.

I have read my MEDICAL HISTORY and confirm that it adequately states past and present conditions.

DATE	PATIENT'S SIGNATURE		EXCEPTIONS	B.P	REVIEWED BY
______	______________________________	None☐	_______________________________	____________	_______________
______	______________________________	None☐	_______________________________	____________	_______________
______	______________________________	None☐	_______________________________	____________	_______________
______	______________________________	None☐	_______________________________	____________	_______________
______	______________________________	None☐	_______________________________	____________	_______________
______	______________________________	None☐	_______________________________	____________	_______________
______	______________________________	None☐	_______________________________	____________	_______________
______	______________________________	None☐	_______________________________	____________	_______________

Signature: ____Date: _____________________

Reviewed by: Doctor____