Patient Name (printed) _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Does your doctor require you to pre-medicate with antibiotics prior to dental appointments?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco, smokeless tobacco, or vape products?	☐	☐
8. Do you have or have you had any of the following?		

	Yes	No		Yes	No		Yes	No		Yes	No
Acid Reflux/Gerd	☐	☐	Convulsions	☐	☐	Heart Trouble/Disease	☐	☐	Radiation Treatments	☐	☐
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Hemophilia	☐	☐	Recent Weight Loss	☐	☐
Alzheimer's Disease	☐	☐	Depression	☐	☐	Hepatitis A__B__C__	☐	☐	Renal Dialysis	☐	☐
Anaphylaxis	☐	☐	Diabetes	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	A1C_____	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐
Angina	☐	☐	Drug Addiction	☐	☐	High Cholesterol	☐	☐	Scarlet Fever	☐	☐
Anxiety	☐	☐	Easily Winded	☐	☐	Hives or Rash	☐	☐	Shingles	☐	☐
Arthritis/Gout	☐	☐	Emphysema	☐	☐	Hypoglycemia	☐	☐	Sickle Cell Disease	☐	☐
Artificial Heart Valve	☐	☐	Epilepsy or Seizures	☐	☐	Irregular Heartbeat	☐	☐	Sinus Trouble	☐	☐
Artificial Joint	☐	☐	Excessive Bleeding	☐	☐	Kidney Problems	☐	☐	Stomach/Intestinal Disease	☐	☐
Asthma	☐	☐	Excessive Thirst	☐	☐	Leukemia	☐	☐	Stroke	☐	☐
Blood Disease	☐	☐	Fainting Spells/Dizziness	☐	☐	Liver Disease	☐	☐	Swelling of Limbs	☐	☐
Blood Transfusion	☐	☐	Frequent Cough	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Breathing Problem	☐	☐	Frequent Diarrhea	☐	☐	Lung Disease	☐	☐	Tonsillitis	☐	☐
Bruise Easily	☐	☐	Frequent Headaches	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐	Osteoporosis	☐	☐	Tumors or Growths	☐	☐
Chemotherapy	☐	☐	Hay Fever	☐	☐	Parathyroid Disease	☐	☐	Ulcers	☐	☐
Chest Pains	☐	☐	Heart Attack/Failure	☐	☐	Psychiatric Care	☐	☐			
Cold Sores/Fever Blisters	☐	☐	Heart Murmur	☐	☐	Any other Conditions/ Illnesses not Listed	☐	☐	Please list_____		
Congenital Heart Disorder	☐	☐	Heart Pacemaker	☐	☐						

	Yes	No
9. Do you use controlled substances?	☐	☐
10. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
11. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you clench or grind your teeth?	☐	☐
9. Have you ever had any difficult extractions in the past?	☐	☐
10. Have you ever had any prolonged bleeding following extractions?	☐	☐
11. Have you had any orthodontic treatment?	☐	☐
12. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
13. Daily sugar intake: Low _____ Med _____ High _____		
14. Number of carbonated beverages consumed daily? _____		
15. Do you often have dry mouth _____		
16. Dry mouth products used? _____		
17. Have your parents experienced tooth loss?	☐	☐
18. Do you like your smile?	☐	☐

Authorization and Release

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. 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 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, including any collection fees that might be incurred.

X _____

Signature of patient (or parent/guardian if minor) Date

Doctor Signature _____ Date