MEDICAL HISTORY

PATIENT NAME _____ Birth Date_____

Check Y for yes or N for no if you have or have not had the following:

Y N Bad breath Y N Food collection between teeth Y N Periodontal treatment Y N Sensitivity
Y N Bleeding gums Y N Grinding or clenching teeth Y N Sores or growths in mouth
How often do you brush?_____How often do you floss?_____
How do you feel about the appearance of your teeth?_____
Do you have dental anxiety? Slight Moderate Severe

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please list: _____
Have you ever taken Fosamax, Boniva, Actonel or any			_____
Other medications containing bisphosphonates?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain why:_____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs

Other If yes, please list:_____

Do you have, or have you had, any of the following? **PLEASE CIRCLE YES OR NO FOR EACH**

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes No
Anemia	Yes	No	Easily Winded	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes No
Angina	Yes	No	Emphysema	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Shingles	Yes No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes No
Blood Transfusion	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes No
Breathing Problem	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes No
Bruise Easily	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes No
Cancer	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes No
Chemotherapy	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes No
Chest Pains	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes No
Cold Sores/Fever Blisters	Yes	No	Heart Pace Maker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes No
Congenital Heart Disorder	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes No
Convulsions	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes No

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

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist 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 Insurance

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Payment is due in full at time of treatment unless prior arrangements have been approved.