

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## Medical Information

Name of Medical Doctor: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Yes No Are you under medical treatment now?

If yes, please explain: \_\_\_\_\_

Yes No Have you been admitted to a hospital or needed emergency care during the past two years?

If yes, please explain: \_\_\_\_\_

Yes No Have you had any operations:

If yes, please list: \_\_\_\_\_

Yes No Are you taking any drugs or medications?

If yes, please list: \_\_\_\_\_

Yes No Have you had any adverse reactions or allergies to any drugs, latex products, or foods?

If yes, please list: \_\_\_\_\_

Please check any condition which you now have, are being treated for, or have had in the past:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Alcohol Abuse      | <input type="checkbox"/> Epilepsy/Seizures       | <input type="checkbox"/> Hip Replacement             | <input type="checkbox"/> Shingles           |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Excessive Bleeding      | <input type="checkbox"/> Kidney Dialysis             | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Angina             | <input type="checkbox"/> Fainting/Dizziness      | <input type="checkbox"/> Kidney Disease              | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Angioplasty        | <input type="checkbox"/> Hay Fever               | <input type="checkbox"/> Kidney Transplant           | <input type="checkbox"/> Tuberculosis (TB)  |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Herpes/Fever Blisters   | <input type="checkbox"/> Knee Replacement            | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Liver Disease               | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Blood Disorder     | <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Low Blood Pressure          | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Blood Transfusion  | <input type="checkbox"/> Head Injuries           | <input type="checkbox"/> Nervous Problems            |   |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Pacemaker                   | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Radiation/Chemotherapy      | Due Date: _____                             |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Heart Stent/Bypass      | <input type="checkbox"/> Rheumatic Fever             |   |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Rheumatism                  | <input type="checkbox"/> Tobacco use:       |
| <input type="checkbox"/> Drug Abuse         | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Sinus Problems              | Kind: _____                                 |
| <input type="checkbox"/> Emphysema          | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Stomach/Intestinal Problems | How much per day: _____                     |

Are there any other medical conditions that we should know about? \_\_\_\_\_

## Dental Information

Yes No Do you have regular dental check-ups? Date of last exam: \_\_\_\_\_

Yes No Have you had any trouble associated with previous dental treatment?

If yes, please explain: \_\_\_\_\_

Yes No Do you clench or grind your teeth?

Yes No Do your gums bleed when you brush your teeth?

Yes No Have you noticed any lumps or sores in your mouth?

Yes No Have you ever had an injury to your face, jaws, or teeth?

Yes No Are you happy with the appearance of your teeth?

Yes No Do you want to save your teeth?

Yes No Has fear ever prevented you from seeking dental treatment?

Yes No Are you allergic to any metals or dental materials?

Yes No Are you allergic to "Novocaine"?

Circle the types of dental treatment you have experienced:

Orthodontics (braces)    Dentures    Fillings    Implants    Root canal treatment  
Oral Surgery    Periodontal (gum) treatment    TMJ treatment    Extractions

Are there any other dental conditions that we should know about? \_\_\_\_\_

## Authorization

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I (or the minor patient) may need during diagnosis and treatment with my informed consent.

I understand that I am financially responsible for all services rendered including any finance charges.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_