Patient Medical History

Physician_____ Office Phone_____ Date of Last Visit_____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized?	☐	☐
3. Are you taking any medications including non-prescription and herbals? If yes, What medications are you taking?	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you consume alcohol?	☐	☐
6. Are you allergic to, or have you had any reaction to any medications or materials such as latex?	☐	☐

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest pain	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis/ Jaundice	☐	☐	Respiratory Problem	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	History of Drug Abuse	☐	☐
Thyroid Problem	☐	☐	Stomach Trouble or Ulcers	☐	☐	Any other disease or condition not listed	☐	☐

Women: Are you pregnant?_____ Do you think you might be pregnant?_____ Are you taking oral contraceptives?_____

Comments

Patient Dental History

	Yes	No
1. Do your gums ever bleed while brushing or flossing?	☐	☐
2. Do you feel pain to any of your teeth?	☐	☐
3. Do you have any sores or lumps in or near your mouth?	☐	☐
4. Have you had any head, neck, or jaw injuries?	☐	☐
5. Have you ever had any prolonged bleeding following an extraction?	☐	☐
6. Have you ever had professional instruction on brushing and flossing your teeth?	☐	☐
7. Do you consume dairy products daily?	☐	☐
8. Do you use any fluoride supplement other than toothpaste?	☐	☐
9. How many in between meal sugar snacks do you have per day on average?	_____	

Comments

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The aforementioned 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.

Patient Signature_____ Date_____

Reviewed by:_____ Date_____