MEDICAL HISTORY

PHYSICIAN'S NAME________________________ LAST PHYSICAL EXAM ____________ AG

PHYSICIAN'S ADDRESS________________________________ TELEPHONE______

ARE YOU ALLERGIC TO ANY MEDICATION (penicillin, novocaine, codiene, aspirin, etc.) ____________

Due to the complexities of modern-day medicine and dentistry, it is imperative to have an accurate medical his record. Some drugs, medications or medical problems may produce side effects when combined with dental prc Please answer YES or NO to each question below. If you do not understand a question, please ask for help.

- ___ Heart failure
- ___ Heart disease
- ___ Angina Pectoris
- ___ High or low blood pressure
- ___ Heart murmur
- ___ Scarlet Fever
- ___ Rheumatic Fever
- ___ Congenital heart disease
- ___ Valvular heart disease
- ___ Heart surgery (bypass)
- ___ Artificial heart valve
- ___ Heart pacemaker
- ___ Leukemia
- ___ Anemia
- ___ Stroke
- ___ Kidney trouble or dialysis
- ___ Ulcers or colitis
- ___ Mononucleosis
- ___ Cancer
- ___ Asthma
- ___ Hay fever or other allergies
- ___ Hives
- ___ Emphysema
- ___ Cough
- ___ Tuberculosis
- ___ Thyroid disease
- ___ Sinus problems
- ___ Diabetes
- ___ Hypoglycemia
- ___ Chemotherapy
- ___ X-ray, Cobalt treatment
- ___ Bleeding problems
- ___ Arthritis/Rheumatism
- ___ Sickle Cell Disease
- ___ Lyme Disease
- ___ Organ transplant
- ___ Artificial joint or replacements
- ___ AIDS or HIV i
- ___ Hepatitis A (in
- ___ Hepatitis B (se
- ___ Liver disease
- ___ Blood transfus
- ___ Alcohol or dru
- ___ Hemophilia
- ___ Venereal disea
- ___ Cold sores
- ___ Epilepsy or sei
- ___ Fainting or di
- ___ Nervousness
- ___ Psychiatric tre
- ___ Eye disorders
- ___ Glaucoma
- ___ Bruise easily
- ___ Pregnant, mor
- ___ Nursing moth
- ___ Birth Control

DESCRIBE ANY CURRENT MEDICAL TREATMENT AND ANY DRUGS TAKEN, EVEN THOUGH NOT LISTED ABOVE

PATIENT INFORMATION AND HEALTH HISTORY

. INITIAL EXAM

DATE ______

PATIENT'S NAME ______ DATE OF BIRTH ______

SINGLE MARRIED LONG TERM PARTNER DIVORCED SEPARATED WIDOWED

PATIENT'S ADDRESS ______ PHONE ______

PERSON RESPONSIBLE FOR THIS ACCOUNT ______ PHONE ______

ADDRESS ______

EMPLOYED BY ______ BUSINESS PHONE ______

BUSINESS ADDRESS ______ PATIENT'S SS# ______

DENTAL INSURANCE PLAN (IF ANY) ______ REFERRED BY ______

PATIENT'S NAME

DENTAL HISTORY

CHIEF ORAL COMPLAINT ______

DATE OF LAST DENTAL EXAM. ______ ANY PREVIOUS MAJOR DENTAL TREATMENT, ☐ YES ☐ NO WHEN ______

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long ______
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits, i.e., fingernail biting cheek biting, etc.
- ☐ Cigarettes, pipe or cigar smoking
- ☐ Texture of toothbrush ______
- ☐ Frequency of brushing ______
- ☐ Dental Floss
- ☐ Inter dental stimulators
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements
- ☐ Alcohol

MEDICAL HISTORY

PHYSICIAN'S NAME ______ DATE OF LAST PHYSICAL EXAM. ______ AGE ______

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Allergies to drugs
- ☐ Allergies to anesthetics
- ☐ Any heart ailments
- ☐ High blood pressure
- ☐ Neurological problems
- ☐ Radiation treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Arthritis
- ☐ Chronic Fatigue Syndrome
- ☐ Asthma
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Latex sensitivity
- ☐ Liver problems or hepatitis
- ☐ Malignancies
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Immune System Disorders (AIDS, HIV, ARC)
- ☐ Stroke
- ☐ Thyroid
- ☐ Eye disorders
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer or colitis
- ☐ Pregnancy If so, what month ______
- ☐ Venereal disease
- ☐ Other ______

Describe any current medical treatment including drugs taken, even though not listed above ______

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE ______ DATE ______

(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)