PATIENT NAME _____ E-Mail _____
HOME ADDRESS _____ DATE OF BIRTH _____
_____ HOME PHONE _____
_____ CELL PHONE _____
BUSINESS ADDRESS _____
_____ BUSINESS PHONE _____
EMPLOYER _____ SS# / SIN _____
INSURANCE CO. _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST MEDICAL EXAM _____

DATE OF LAST DENTAL EXAM _____

Emergency Contact Name and Phone:

Weight:

		YES	NO
1	Are you under medical treatment now?	☐	☐
2	Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3	Are you taking any medication(s) including non-prescription medicine?	☐	☐
	if yes, what medication(s) are you taking? _____	☐	☐
4	Have you ever taken Fen-Phen/Redux? **Bisphosphonates?**	☐	☐
5	Do you use Tobacco?	☐	☐
6	Do you use alcohol, cocaine or other drugs?	☐	☐
7	Are you wearing contact lenses?	☐	☐

8 Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Local anesthetics (eg. Novocaine)	☐	☐	Barbiturates	☐	☐	Asprin
☐	☐	Penicillin or other antibiotics	☐	☐	Sedatives	☐	☐	Other _____
☐	☐	Sulfa Drugs	☐	☐	Iodine	☐	☐	

9 WOMEN ONLY:

		YES	NO
a)	Are you pregnant or think you may be pregnant?	☐	☐
b)	Are you nursing?	☐	☐
c)	Are you taking birth control pills?	☐	☐

10 Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ ☐

11 Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Congenital Heart Disease	☐	☐	Chest Pains
☐	☐	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 / High Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble
☐	☐	Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems
☐	☐	AIDS or HIV infection	☐	☐	Sexually Transmitted Disease	☐	☐	Blood Transfusion
☐	☐	Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Chronic Obstructive Pulmonary Disease
☐	☐	Bacteria Endocarditis	☐	☐	Prosthetic Cardiac Valve	☐	☐	Psychiatric/Psychological Treatment
			☐	☐	Tattoo or Body Piercing	☐	☐	Other _____

COMMENTS

BRUSH: _____ x Daily

FLOSS: _____ x Weekly

Referred by: _____

X-RAY

Dr's Signature

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?	☐	☐
	a) Clicking?	☐	☐
	b) Pain (joint, ear, side of face)?	☐	☐
	c) Difficulty in opening or closing?	☐	☐
	d) Difficulty in chewing?	☐	☐
8	Do you have frequent headaches?	☐	☐
9	Do you clench or grind your teeth?	☐	☐
10	Do you bite your lips or cheeks frequently?	☐	☐
11	Have you ever had any difficult extractions in the past?	☐	☐
12	Have you had any orthodontic treatment?	☐	☐
13	Have you ever had prolonged bleeding following extractions?	☐	☐
14	Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15	Have you ever had instructions on the care of your gums?	☐	☐

I certify that I have read and understand the above information to the best of my knowledge, the above questions have been accurately answerd. I understand that providng incorrect information can be dangerous to my health.

SIGNATURE X _____ _____

PATIENT, PARENT OR GUARDIAN DATE