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:

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