1. ARE YOU IN GOOD HEALTH? [ ] NO [ ]

2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE LAST YEAR? [ ] NO [ ]

3. DATE OF YOUR LAST PHYSICAL EXAM? [ ] NO [ ]

4. PHYSICIAN'S NAME [ ] ADDRESS [ ] PHONE NO. [ ]

5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN? [ ] NO [ ]

6. HAVE YOU EVER BEEN HOSPITALIZED OR HAD ANY SURGICAL OPERATION OR SERIOUS ILLNESS? [ ] NO [ ]

7. ARE YOU TAKING ANY MEDICINE(S)? [ ] NO [ ] INCLUDING NON-PRESCRIPTION MEDICINE [ ] IF YES, WHAT MEDICINE(S) ARE YOU TAKING [ ]

8. HAVE YOU HAD ANY ABNORMAL BLEEDING? [ ] NO [ ]

9. DO YOU BRUISE EASILY? [ ] NO [ ]

10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION? [ ] NO [ ]

11. HAVE YOU EVER TAKEN FEN-PhEN/Redux? [ ] NO [ ]

12. DO YOU USE TOBACCO? [ ] NO [ ]

13. DO YOU OR DO YOU HAVE YOU USED CONTROLLED SUBSTANCES? [ ] NO [ ]

14. ARE YOU WEARING CONTACT LENSES? [ ] NO [ ]

15. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)? [ ] NO [ ]

16. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT? [ ] NO [ ]

17. ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? [ ] NO [ ]

18. ARE YOU NURSING? [ ] NO [ ]

19. ARE YOU TAKING BIRTH CONTROL PILLS? [ ] NO [ ]

20. ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO: [ ]

   - LOCAL ANESTHETICS LIKE NOVOCAIN [ ]
   - PENICILLIN OR OTHER ANTIBIOTICS [ ]
   - SULFA DRUGS [ ]
   - BARBITURATES, SEDATIVES OR SLEEPING PILLS [ ]
   - ASPIRIN [ ]
   - RADIATION [ ]
   - ANY METALS (E.G., NICKEL, MERCURY, ETC.) [ ]
   - LATEX/RUBBER [ ]
   - OTHER (PLEASE LIST) [ ]

   DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING: [ ]

   - RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER [ ]
   - SCARLET FEVER [ ]
   - HEART DEFECT OR HEART MURMUR [ ]
   - HEART TROUBLE, HEART ATTACK, OR ARGINA [ ]
   - CHEST PAIN [ ]
   - SHORTNESS OF BREATH [ ]
   - PACEMAKER [ ]
   - HEART SURGERY [ ]
   - HIGH/LOW BLOOD PRESSURE [ ]
   - CONGENITAL HEART PROBLEM [ ]
   - SWELLING OF FEET, ANKLES, HANDS [ ]
   - HEPATITIS, LIVER DISEASE [ ]
   - STROKE [ ]
   - SINUS TROUBLE [ ]
   - LUNG OR BREATHING PROBLEMS [ ]
   - ASTHMA OR ARF [ ]
   - HIVES OR SKIN RASH [ ]
   - Fainting or dizzy spells [ ]
   - DIABETES [ ]
   - AIDS OR HIV INFECTION [ ]
   - THYROID PROBLEMS [ ]
   - ALLERGIES [ ]
   - ARTHRITIS OR RHEUMATISM [ ]
   - JOINT REPLACEMENT OR IMPLANT [ ]
   - STOMACH ULCER [ ]
   - KIDNEY TROUBLE [ ]
   - TUBERCULOSIS [ ]
   - PERSISTENT COUGH [ ]
   - COUGH THAT PRODUCES BLOOD [ ]
   - CHEMOTHERAPY (CANCER, LEUKEMIA) [ ]
   - SEXUALLY TRANSMITTED DISEASE [ ]
   - EPILEPSY OR SEIZURES [ ]
   - ANEMIA [ ]
   - GLAUCOMA [ ]
   - NEUROPATHY [ ]
   - TOXICITY [ ]
   - MENTAL HEALTH CARE [ ]
   - BACK PROBLEMS [ ]
   - CHEMICAL DEPENDENCY [ ]
   - MENTAL VALVE PROLAPSE [ ]
   - CORTISONE TREATMENT [ ]
   - COLD SHOCKS/EVER BUSTERS [ ]
   - HYPOGLYCEMIA [ ]
   - EATING DISORDERS [ ]

[ ] MALE [ ] FEMALE
## PATIENT DENTAL HISTORY

**Patient’s Name**

**Date of Birth**

### Reason for This Visit

**When Was Your Last Dental Visit**

**How Often Do You Visit the Dentist Before Then**

**Previous Dentist (Name and Location)**

**Have You Had a Complete Series of Dental Films (X-Rays) Taken When Where**

**How Often Do You Brush Your Teeth**

**How Often Do You Floss Your Teeth**

**Is Your Drinking Water Fluoridated**

### Do Your Gums Bleed While Brushing: Yes No

**Or Flossing**

**Are Your Teeth Sensitive to Hot or Cold Liquids/Foods**

**Are Your Teeth Sensitive to Sweet or Sour Liquids/Foods**

**Do You Feel Pain to Any of Your Teeth**

**Do You Have Any Sores or Ulcers in or Near Your Mouth**

**Have You Had Any Head, Neck or Jaw Injuries**

**Have You Ever Experienced Any of the Following Problems in Your Jaw**

- **Clicking**
- **Pain (Joint, Ear, Side of Face)**
- **Difficulty in Opening or Closing**
- **Difficulty in Chewing**
- **Do You Have Frequent Headaches**
- **Do You Clench or Grind Your Teeth**

### If You Could Change Anything About Your Smile, What Would You Change?

### Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above 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 diagnoses and the records of any treatment of 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.

**Signature of Patient or Parent/Guardian if Minor**

**Date**

### Doctor's Comments

**Signature**

**Date**

### Health History

**Patient Number**