Smile, it is the key that fits the lock of everybody's heart.

4 Medical History *continued*

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:_____

Phone #: (____) _____ Date of last visit:_____

Your current physical health is: ❑ **Good** ❑ **Fair** ❑ **Poor**

Are you currently under the care of a physician? ❑ Yes ❑ No

Please Explain:_____

Have you taken Bisphosphanate (Fosamax) in the last 3 months? ❑ Yes ❑ No

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you ever had any metal rods, pins or implants? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No

Please list each one:_____

_____

Weight_____ Height_____ Age_____

Have you ever experience an adverse reaction during or in conjunction with a medical or dental procedure?

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Jewelry/Metals	Y N Tetracycline
Y N Dental Anesthetics	Y N Latex	Y N Other

Please list any other drugs/materials that you are allergic to:_____

_____

Have you ever had any of the following diseases or medical problems?

Y N	Abnormal Bleeding/Hemophilia	Y N	Herpes/Fever Blisters
Y N	AIDS	Y N	High Blood Pressure
Y N	Alcohol/Drug Abuse	Y N	HIV*
Y N	Anemia	Y N	Hospitalized for any reason
Y N	Arthritis	Y N	Kidney Problems
Y N	Artificial Bone/Joints/Valves	Y N	Liver Disease
Y N	Asthma	Y N	Low Blood Pressure
Y N	Blood Transfusion	Y N	Lupus
Y N	Cancer/Chemotherapy	Y N	Mitral Valve Prolapse
Y N	Colitis	Y N	Pacemaker
Y N	Congenital Heart Defect	Y N	Psychiatric Problems
Y N	Diabetes	Y N	Radiation Treatment
Y N	Difficulty Breathing	Y N	Rheumatic/Scarlet Fever
Y N	Emphysema	Y N	Seizures
Y N	Epilepsy	Y N	Shingles
Y N	Fainting Spells	Y N	Sickle Cell Disease/Traits
Y N	Frequent Headaches	Y N	Sinus Problems
Y N	Glaucoma	Y N	Stroke
Y N	Hay Fever	Y N	Thyroid Problems
Y N	Heart Attack/Heart Surgery	Y N	Tuberculosis (TB)
Y N	Heart Murmur	Y N	Ulcers
Y N	Hepatitis	Y N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

For Women:

Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #:_____

Are you nursing? ❑ Yes ❑ No

5 Dental History

What is the purpose of your dental visit?_____

Are you currently in pain? ❑ Yes ❑ No

If you could change anything about your teeth what would it be?

_____

In an attempt to make your experience outstanding, if you have had any past negative dental experiences, please explain_____

_____

_____

_____

Are there any special limitations that might stop you from having dental care? Any special concerns about: financing, time, fear (of pain) (please circle) If other, please explain_____

_____

Your current dental health is: ❑ **Good** ❑ **Fair** ❑ **Poor**

Have you ever had gum treatment? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

Are your teeth sensitive to hot, cold or anything else? _____

Are you interested in a white smile? ❑ Yes ❑ No

Are you interested in straighter teeth? ❑ Yes ❑ No

Clench or grind your teeth while you're asleep or awake? ❑ Yes ❑ No

Do you snore loudly? ❑ Yes ❑ No

Has anyone observed you stop breathing during sleep? ❑ Yes ❑ No

Are you sleepy during the daytime? ❑ Yes ❑ No

I understant that the information that 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 responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein.

Initials:_____ Date:_____

Doctor's Comments:

_____

_____

_____

Our Office is HIPPA Compliant and committed to meeting or exceeding the standards of information safekeeping mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY UPDATE

Has there been any changes in your health status since your last visit? ❑ Yes ❑ No

If yes, please explain. _____

Has there been any changes in your health status since your last visit? ❑ Yes ❑ No

If yes, please explain. _____

_____ Dentist/Hygenist Signature Date

_____ Patient Signature Date

_____ Dentist Signature Date

We all smile in the same language