Patient Name: _____

MEDICAL HISTORY

Do you have a personal physician? Y N

Are you currently under a physician's care? Y N

Physician's Name: _____

Physician's Phone #: _____

YOUR CURRENT PHYSICAL HEALTH IS:

GOOD FAIR POOR

Do you smoke or use tobacco in any form? Y N

Do you have any implants, valves, rods or pins? Y N

Are you taking any medications? Y N

Please list: _____

_____

Have you ever had any of the following diseases or Medical Problems?
(Please answer all that apply)

Y	N	Alcohol/Drug Abuse	Y	N	Hepatitis A B C
Y	N	Anemia	Y	N	Herpes
Y	N	Arthritis	Y	N	High Blood Pressure
Y	N	Artificial Joints/Valves	Y	N	HIV/AIDS
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Bleeding Problems	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer/Chemo	Y	N	Mitral Valve Prolepses
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting/Dizzy Spells	Y	N	Shingles
Y	N	Migraines	Y	N	Sickle Cell Trait/Disease
Y	N	Heart Attack	Y	N	Sinus Problems
Y	N	Heart Murmur	Y	N	Stroke
Y	N	Hemophilia	Y	N	Ulcers

Please list any serious medical condition(s) that are not listed above:

_____

_____

Are you Allergic to any of the following? (Please Circle)

Aspirin	Erythromycin	Metals
Codeine	Jewelry	Penicillin/Amoxycillin
Dental Anesthetics	Latex	Tetracycline

FOR WOMEN: Are you taking birth control pills? Y N

Are you pregnant? Y N Week#: _____

Are you nursing? Y N

DENTAL HISTORY

What is the primary reason for your visit today?

_____

Are you currently in pain? Y N

Do you require antibiotics before dental treatment? Y N

YOUR CURRENT DENTAL HISTORY IS:

GOOD FAIR POOR

When was the last time you had a complete dental evaluation?

Have you ever had a serious/difficult problem associated with _____

any previous dental work? Y N Brush 1 2 3 Times/Daily

Do you floss regularly? Y N Floss 1 2 3 Times/Daily

Have you ever been informed or treated for the following?

Y	N	Bleeding Gums	Y	N	Mobility of Teeth
Y	N	Bad Taste/Odor	Y	N	Oral Cancer/Biopsy
Y	N	Cold Sores/Ulcers	Y	N	Osseous Surgery
Y	N	Deep Cleanings/Scaling	Y	N	TMJ/TMD Joint Pain
Y	N	Gum/Periodontal Disease	Y	N	Toothbrush Abrasion
Y	N	Hot/Cold Sensitivity	Y	N	Wisdom Teeth Extract

SMILE QUESTIONNAIRE

Would you like fresher breath? Y N

Would you like whiter teeth? Y N

Are you happy with how your smile looks? Y N

If not, what would you change? _____

_____

WORK AUTHORIZATION & FINANCIAL POLICY

* The undersigned hereby authorizes Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated.I also understand the use of anesthetic agents embodies certain risk. I understand that responsibility for payment for Dental Services provided in this office for my self or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

PATIENT'S (PARENT) SIGNATURE

_____

DATE _____

DENTIST INITIALS _____