

1. Do you have, or have you had any of the following:

- Anemia
- Heart Murmur
- Mitral Valve Prolapse
- High Blood Pressure
- Rheumatic Fever
- Respiratory Disease
- Tuberculosis
- Nervous Disorders
- Diabetes
- Excessive Bleeding

- Hip or Joint Replacement
- Blood Diseases
- Hepatitis, Jaundice, or Liver Disease
- Kidney Disease
- Tumors or Growths
- Radiation Treatment of Any Kind
- Allergies
- Asthma or Hay Fever
- Glaucoma

- Fainting Spells or Seizures
- Sinus Trouble
- Rheumatism or Arthritis
- Head Injuries
- Stomach Ulcers
- Venereal Disease
- Epilepsy
- Stroke

1. Are you in good health?  Yes  No
2. Date of last medical exam \_\_\_\_\_
3. Have you ever been hospitalized?  Yes  No  
If so, what was the problem? \_\_\_\_\_
4. Are you taking any drugs or medication?  Yes  No  
If so, what? \_\_\_\_\_
5. Do you have any disease, problem or condition you think I should know about? \_\_\_\_\_

10. Do you smoke?  Yes  No
11. Do you wear a cardiac pacemaker?  Yes  No
12. Have you had heart surgery?  Yes  No
13. Are you now under care of M.D.?  Yes  No
14. Have you had any serious illness?  Yes  No
15. Blood Pressure, if known \_\_\_\_\_
16. Do you have any sensitivity to latex?  Yes  No
17. Do you have a history of chemical dependency?  Yes  No  
(If yes, then the dentist will follow up in confidence.)

6. Do you have any disease or have you had a transplant operation that has depressed your immune system?  Yes  No
7. Have you ever taken Fen-Phen?  Yes  No
9. Are you sensitive or allergic to any drugs?  Yes  No  
If so, please list \_\_\_\_\_

Physician's name _____		
Address _____	Phone _____	

FOR WOMEN ONLY

Are you taking birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how long?	<input type="checkbox"/> 1 - 3 mos.	<input type="checkbox"/> 3 - 6 mos.	<input type="checkbox"/> 6 - 9 mos.
Physician's name _____				
Address _____ Phone ( ) _____				

DENTAL HISTORY

1. How long since your last visit to a dentist? \_\_\_\_\_
2. Reason for this visit? \_\_\_\_\_
3. How often do you floss your teeth? \_\_\_\_\_
4. Have you ever been treated for periodontal disease?  Yes  No
5. Have you ever had any complications from an extraction?  Yes  No  
If yes, explain \_\_\_\_\_
6. Have you ever had a popping or clicking near your ear when you chew?  Yes  No
7. Are you prone to frequent headaches?  Yes  No
8. Do you grind or clench your teeth?  Yes  No
9. Do your gums bleed when you brush?  Yes  No
10. Do you have sores, blisters, or swelling on your gums, lips or cheeks?  Yes  No
11. Have you ever had orthodontic treatment?  Yes  No
12. If you could change something about your smile what would it be? \_\_\_\_\_
13. Do you snore?  Yes  No
14. Do you have problems with bad breath?  Yes  No
15. Have you ever had an allergic reaction to a metal filling, crown or dental appliance?  Yes  No
16. Have you ever used an electronic toothbrush?  Yes  No

Previous Dentist \_\_\_\_\_ City \_\_\_\_\_ Phone ( ) \_\_\_\_\_

REMARKS

IS THERE ANY ADDITIONAL MEDICAL OR DENTAL INFORMATION WE MAY NEED TO KNOW ABOUT BEFORE BEGINNING TREATMENT? \_\_\_\_\_

CONSENT

Minor: I, being the parent (or guardian) of the above named minor patient, do hereby authorize the performance of dental services upon this patient and whatever procedures the judgement of the doctor may dictate in order to carry out treatment procedures as outlined on the treatment plan form. I also authorize and request the administration of such anesthetics and/or sedatives as may be deemed advisable by the doctor.

Adult: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

I understand that my dental care insurance carrier or payor of my dental benefits may allow less than the actual bill of services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I agree to be responsible for payment of services not paid, in whole or in part, by my dental care payor.

I attest to the accuracy of the information on this page.

Relative \_\_\_\_\_ Date \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_