Patient Dental and Medical History

█████ ______________________________ ███ ____________

Answers to the following questions will be considered confidential.

Previous Dentist ______________________ Date of last visit ____________

Do have any current information or x-rays on file that could be important to your care ____________

Are you having pain or discomfort at this time?	Yes	No
Do you have Trouble chewing food?	Yes	No
Has anyone ever said you clench or grind your teeth?	Yes	No
Can we help you with Orthodontic treatment?	Yes	No
Have you ever been diagnosed with Gum Disease or Periodontal Disease?	Yes	No
Can we help you with whitening your teeth?	Yes	No

How would you like to improve your teeth and smile? ______________________

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Is there anything that we can do to make you more comfortable here? ______________________

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Medical Doctor ______________________ Date of last visit ____________

Have you been under the care of a medical doctor during the past two years?	Yes	No
Are you or have you taken any bone enhancing or bone density medications?	Yes	No

Please list any medications you are taking at this time ______________________

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Please list any medications you are Allergic to ______________________

Are you Allergic to latex?	Yes	No
Have you ever had any excessive bleeding that requires special treatment?	Yes	No

Do you have or ever had any of the following:

Heart Disease	Cancer	Rheumatic Fever	High Blood Pressure
Heart Murmur	Radiation Therapy	Epilepsy or Seizure	Low Blood Pressure
Pacemaker	Chemotherapy	Liver Disease	Head/Back/Neck Problems
Congenial Heart Lesions	Diabetes	Hepatitis	Chemical/Alcohol Dependency
Emphysema	Anemia	Kidney Problems	Psychiatric Care
Cough	Glaucoma	Stroke	Venereal Diseases
Blood Transfusion	Tuberculosis	Thyroid Disease	Any type of Implant
Hemophilia	Asthma	Sinus Problems	Artificial Joint
Blood Disorders	Arthritis	Ulcers	Use of Tobacco Products
HIV positive	Allergies	Herpes/Cold Sores	____________

WOMEN: Are you pregnant?	Yes	No

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in completion of this form. I herby give my consent for necessary dental x-rays for the diagnosis and treatment of my oral health. I understand that I am personally responsible for all charges associated with my care.

███ ______________________________ ██ ____________