MEDICAL HISTORY

21. Do you have or have you ever had any of the following? Please circle

Organ Transplant	**Joint / Hip replacement**	**Pacemaker**	**Head/ neck injuries**
High Blood Pressure	**Congenital Heart Disease**	**Stroke/ Heart Attack**	**Mitral valve prolapse**
Anemia/ Blood Disorders	**Heart Valve Replacement**	**Heart Murmur**	**Chest pain /Angina**
Ulcers/Stomach Disorders	**Emphysema / Lung disease**	**Kidney Disease**	**Thyroid disease**
Gall bladder disorders	**Liver Disease / Hepatitis A/B/C**	**Osteoporosis**	**Arthritis / Rheumatism**
Sinus or Nasal problems	**Diabetes, Hyper / Hypoglycemia**	**Steroid therapy**	**Tuberculosis**
Mental/ Nervous Disorders	**Down Syndrome / Cerebral Palsy**	**Epilepsy / seizures**	**ADD / autism**
Drug/Alcohol dependency	**Sexually Transmitted Disease**	**H.I.V. / A.I.D.S.**	**Eczema / Psoriasis**
Deafness or Blindness	**Multiple Sclerosis**	**Cancer**	**Rheumatic fever**

• Please list any conditions or diseases not listed above that you have or have had: _____

For women only:

Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? _____ ☐ YES ☐ NO

Are you taking birth control pills? _____ ☐ YES ☐ NO

Are you menopausal or post-menopausal? If so, are you on hormone replacement therapy? _____ ☐ YES ☐ NO

DENTAL HISTORY

1. What has brought you to our office today? _____

2. How often do you usually visit a dental office? _____ When was your last visit? _____

3. What was done at last visit? _____ Were X-rays taken? ☐ YES ☐ NO

4. Have you ever had a negative dental experience? If yes, please explain: _____ ☐ YES ☐ NO

5. Are you generally tense during dental treatment? ☐ YES ☐ NO

6. Have you ever suffered an accident involving your face or jaws? If so, when? _____ ☐ YES ☐ NO

7. Do you have any of the following? Please circle. **Discomfort** **Pain** **Sensitivity** **Infection / swelling**

If so, where? _____ Since when _____

8. Do you have any of the following? Please circle.

			Broken fillings or teeth
Bad breath	**Food collection between teeth**	**Periodontal treatment**	**Bleeding or irritated gums**
Loose teeth	**Sores or growth in mouth**	**Clicking or popping jaws**	**Grinding or clenching teeth**

9. How many times a day do you brush? _____ How many times a day do you use floss? _____

10. If there is anything you would change about your smile, what would it be? _____

To the best of my knowledge, the above information is correct and I have not omitted any pertinent information. I hereby consent to performing whatever is deemed necessary for proper diagnosis and treatment. These may include the use of x-ray, local anesthesia, and other medication. I understand that treatment options will be discussed and I have the right to be provided answers to questions which may arise during the course of treatment. Further, I understand the risk, benefits, and possible complications of dental treatment. I also understand that complications could change treatment.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ NAME (Please print): _____ DATE: ___/___/___ MM/DD/YY

DENTIST SIGNATURE: _____ DATE: ___/___/___ MM/DD/YY