Patient Name		Home Phone	Home Address	
Soc. Sec. No.	Employer	Work Phone	City State Zip	
Responsible Party		Home Phone	Home Address City State Zip	
Type of Dental Insurance		Cell Phone	Date of Birth	Marital Status
Person to notify in case of emergency		Phone No.	Referred By:	
Physician	E-Mail Address		Date of last exam	Today's Date

PATIENT MEDICAL HISTORY

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicines?	☐	☐
4. Do you use tobacco?	☐	☐
5. Are you taking or have ever taken Actonel, Fosamax, Boniva or other Bisphosphonates?	☐	☐
6. Do you use alcohol?	☐	☐
7. Do you use cocaine or other drugs?	☐	☐
8. Are you allergic or had an adverse reaction to any drugs or medications?	☐	☐
9. Are you in good health at this time?	☐	☐
10. Are you pregnant, think you may be pregnant, or a nursing mother?	☐	☐

11. DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
( )	( )	High Blood Pressure	( )	( )	Heart Disease	( )	( )	Chest Pain
( )	( )	Heart Attack	( )	( )	Cardiac Pacemaker	( )	( )	Easily Winded
( )	( )	Rheumatic Fever	( )	( )	Heart Murmur	( )	( )	Stroke
( )	( )	Swollen Ankles	( )	( )	Angina	( )	( )	Hay Fever/Allergies
( )	( )	Fainting/Seizures	( )	( )	Frequently Tired	( )	( )	Tuberculosis
( )	( )	Asthma	( )	( )	Anemia	( )	( )	Radiation Therapy
( )	( )	Low Blood Pressure	( )	( )	Emphysema	( )	( )	Glaucoma
( )	( )	Epilepsy/Convulsions	( )	( )	Cancer	( )	( )	Recent Weight Loss
( )	( )	Leukemia	( )	( )	Arthritis	( )	( )	Liver Disease
( )	( )	Diabetes	( )	( )	Joint Replacement/Implant	( )	( )	Heart Trouble
( )	( )	Kidney Diseases	( )	( )	Hepatitis/Jaundice	( )	( )	Respiratory Problems
( )	( )	Aids or HIV Infection	( )	( )	Sexually Transmitted Disease	( )	( )	Sinus Problems
( )	( )	Thyroid Problem	( )	( )	Stomach Troubles/Ulcers	( )	( )	Other

COMMENTS

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Dentist Date

PATIENT DENTAL HISTORY

Last Dental Visit? _____ What Services? _____

What is your chief dental complaint? _____

Have you lost teeth? _____ Why _____

Complications with extractions or dental treatment _____

Missing teeth replaced by _____ Bridge _____ Removable Partial _____ Denture _____

Have replacements been discussed? _____ How do you feel about your teeth in general?

Are you pleased with the appearance of your teeth? _____ If no, what concerns _____

Do your gums bleed when chewing? _____ Brushing? _____ Flossing? _____

Are your teeth sensitive to sweets? _____ Hot? _____ Cold? _____

Does food collect between your teeth? _____

Do you have frequent headaches, pain or clicking in your jaws, or pain when opening? _____

Do you clinch or grind your teeth while awake or asleep? _____

Have you ever had instructions on the correct method of brushing and flossing? _____

Have you ever had an unpleasant dental experience? _____

I certify I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature (patient, parent or guardian) _____