Patient Medical Information

Patient name:_____ Date: _____

Physician: _____Office #: _____ Date of last exam: _____

Are you under medical treatment now? Yes No

Are you taking any medication (s) including non-prescription medicine? Yes No

If yes, what medication (s) are you taking?

_____

_____

Have you been hospitalized for any surgical operation or serious illness within the last 5 yrs? Yes No

If yes, please explain:_____

_____

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Are you pregnant or think you may be pregnant? Yes No

Are you nursing? Yes No

Are you taking oral contraceptives? Yes No

Are you allergic to or have you had any reactions to the following?

Local anesthetics (ex. novocaine)	**Yes No**
Penicillin	**Yes No**
Sulfa drugs	**Yes No**
Barbiturates	**Yes No**
Aspirin	**Yes No**
Sedatives	**Yes No**
Iodine	**Yes No**
Latex rubber	**Yes No**
Any metals (eg. Nickel, mercury etc)	**Yes No**
Other antibiotics -please list_____	**Yes No**
_____	
Other _____	**Yes No**
_____	

Do you have or have you had any of the following?

High blood pressure	Yes No	Heart disease	Yes No	Chest pains	Yes No
Heart attack	Yes No	Cardiac Pacemaker	Yes No	Anemia	Yes No
Rheumatic fever	Yes No	Heart murmur	Yes No	Stroke	Yes No
Swollen ankles	Yes No	Angina	Yes No	Hay fever/Allergies	Yes No
Fainting/Seizures	Yes No	Mitral valve prolapse	Yes No	Tuberculosis	Yes No
Asthma	Yes No	Emphysema	Yes No	Radiation therapy	Yes No
Low blood pressure	Yes No	Artificial valves/other valves	Yes No	Glaucoma	Yes No
Epilepsy/Convulsions	Yes No	Cancer	Yes No	Recent weight loss	Yes No
Leukemia	Yes No	Arthritis	Yes No	Liver Disease	Yes No
Diabetes	Yes No	Joint replacement/Implant	Yes No	Heart trouble	Yes No
Kidney disease	Yes No	Hepatitis/Jaundice	Yes No	Respiratory problems	Yes No
AIDS/HIV infection	Yes No	Sexually transmitted disease	Yes No	Frequently tired	Yes No
Thyroid problem	Yes No	Stomach troubles/Ulcers	Yes No	Other:_____	Yes No

Name of previous dentist and location: _____ Date of last dental exam: _____

Do your gums bleed while brushing or flossing?	Yes No	Do you have frequent headaches?	Yes No
Are your teeth sensitive to hot or cold liquids/foods?	Yes No	Do you clench or grind your teeth?	Yes No
Are your teeth sensitive to sweet or sour liquids/foods?	Yes No	Do you bite your lips or cheeks frequently?	Yes No
Do you feel pain in any of your teeth?	Yes No	Have you had any difficult extractions?	Yes No
Do you have sores or lumps on or near your mouth?	Yes No	Have you had any prolonged bleeding following an extraction?	Yes No
Have you had any neck, head, or jaw injuries?	Yes No		
Do you wear dentures or partials?	Yes No		

If yes to above, date of prior placement_____

Have you experienced any of the following problems in your jaw?

Pain (joint, ear, side of face): Yes No Difficulty in opening or closing: Yes No

Clicking: Yes No Difficulty in chewing: Yes No

Authorization and Release:

I certify that 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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to the third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent if minor)