MEDICAL HISTORY (continued)

Are you taking any perscription/over-the-counter/herbal supplement drugs? □ Yes □ No

If yes, please list medications and dosages:_____

Women: Are you pregnant? □ Yes □ No Week#:____ Are you nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Are you allergic to any of the following?

□ Aspirin	□ Metals	□ Erythromycin
□ Codeine	□ Jewelry	□ Penicillin
□ Dental Anesthetics	□ Latex	□ Tetracycline

Please list any other allergies:_____

Check (√) if you have any of the following:

□ AIDS	□ Congenital Heart Lesions	□ HIV Positive	□ Shingles
□ Alcohol /Drug Abuse	□ Cortisone Treatments	□ Jaw Pain	□ Shortness of Breath
□ Anemia	□ Diabetes	□ Kidney Disease	□ Sickle Cell Disease
□ Arthritis, Rheumatism	□ Epilepsy	□ Liver Disease	□ Sinus Problems
□ Artificial Heart Valves	□ Fainting	□ Low Blood Pressure	□ Skin Rash
□ Artificial Joints	□ Glaucoma	□ Mitral Valve Prolapse	□ Stroke
□ Asthma	□ Headaches	□ Nervous Problems	□ Swelling of Feet/Ankles
□ Back Problems	□ Heart Murmur	□ Pacemaker	□ Thyroid Problems
□ Bleeding Abnormally	□ Heart Problems	□ Psychiatric Care	□ Tobacco Habit
□ Blood Disease	Explain:_____	□ Radiation Treatment	□ Tonsillitis
□ Cancer	□ Hemophilia	□ Respiratory Disease	□ Tuberculosis
□ Chemical Dependency	□ Hepatitis	□ Rheumatic Fever	□ Ulcer
□ Chemotherapy	□ High Blood Pressure	□ Scarlet Fever	□ Venereal Disease
□ Circulatory Problems			

DENTAL HISTORY

Name of Former Dentist:_____ Former Dentist's Ph #: (____)_____

Date of last exam:_____ Date of last x-rays:_____ Reason for today's visit_____

Have you ever had any serious problems associated w/ previous dental treatment:_____

How many times a day do you brush?_____ How many times a week do you floss?_____

Please (√) any of the following conditions that

□ Bad Breath	□ Grinding Teeth	□ Sensitivity to Heat
□ Bleeding Gums	□ Loose Teeth or Broken Fillings	□ Sensitivity to Sweets
□ Clicking or Popping Jaw	□ Periodontal Treatment	□ Sensitivity when Biting
□ Food Collection Between Teeth	□ Sensitivity to Cold	□ Sores or Growths in Your Mouth

CERTIFICATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I also understand that this information will be held in the strictest confidence. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature:_____ Date:_____

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature:_____ Date:_____

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Medical History Update

Date:_____ Comments:_____ Initials:_____

Date:_____ Comments:_____ Initials:_____

Date:_____ Comments:_____ Initials:_____

Date:_____ Comments:_____ Initials:_____

Date:_____ Comments:_____ Initials:_____