

Patient Name _____

Date _____

Medical History

- YES NO 1. Are you under the care of a physician?
If so, what is the condition being treated? _____
- YES NO 2. Have you had any serious illness or operation?
If so, what and what year? _____
3. Do you have or have you had any of the following conditions or problems?
- YES NO A. Rheumatic fever or Rheumatic heart disease?
- YES NO B. Congenital heart lesions, heart murmurs, or Mitral Valve Prolapse?
- YES NO C. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency
Coronary occlusion, high blood pressure, arteriosclerosis, stroke)
- YES NO D. HIV or AIDS (Acquired Immune Deficiency Syndrome)
- YES NO E. HPV
- YES NO F. Hepatitis
- YES NO G. Diabetes
- YES NO H. Do you have any type of valve or pacemaker for your heart?
- YES NO I. Allergies?
- YES NO J. Sinus Trouble?
- YES NO K. Fainting spells or seizures?
- YES NO L. Tuberculosis?
- YES NO M. Do you have a joint prosthesis (artificial hip, knee, etc.)?
Other _____ Date of Placement _____
- YES NO 4. Do you smoke? _____ Chew tobacco? _____ Dip Snuff? _____
- YES NO 5. Have you had surgery or x-ray treatment for a tumor, growth or other condition?
- YES NO 6. Have you had abnormal bleeding associated for a tumor, growth, or other condition?
- YES NO 7. Are you taking any drug, medication, or pill? If so, please list: _____
- YES NO 8. Are you allergic to or have you reacted adversely to:
- A. Local anesthetics?
- B. Penicillin or other antibiotics?
- C. Codeine?
- D. Aspirin?
- E. Sulfa?
- YES NO 9. Women- Are you pregnant?
- YES NO 10. Do you take or have you taken bisphosphonates? (Actonel, Fosamax, Boniva, Reclast
Didronel, etc.)?

Dental History

1. Reason for present visit? _____
2. Last visit to dentist? _____
3. What is the usual frequency that you have your teeth cleaned? _____
- YES NO 4. Have you ever had a tooth removed?
- YES NO 5. Do your gums bleed easily?
- YES NO 6. Have you had any unusual difficulties with any previous dental treatment?
- YES NO 7. Are you satisfied with the appearance of your teeth?
- YES NO 8. Is there any condition that you feel your dentist should know about before
Undertaking treatment? If so, describe: _____

To the best of my knowledge, the above medical and dental history is correct. I hereby consent to such examinations, x-rays, and diagnostic procedures, as well as any treatment you may prescribe. I accept full responsibility of payment for services provided.

(Signature of Patient, Parent or Legal Guardian)