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 in what year? _____

3. Do you have or have you had any of the following conditions or problems?
Please circle each that applies.

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_____ Name of Surgeon_____

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. Do you have any allergies?
If so, please list: _____
YES NO 9. Women- Are you pregnant?
YES NO 10. Do you take or have you taken bisphosphonates? Please circle: Actonel Fosamax Boniva Reclast, Didronel Zometa Binosto Aclasta Aredia Atelvia Skelid

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 prior to 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.

_____ _____

(Signature of Patient, Parent or Legal Guardian) (Signature of Dentist)