			Office Phone		Date of Last Exam		
		Yes	No			Ye	es
1. Are you under medical treatment nov	۸Ś			10. Are you	wearing contact lenses?		
2. Have you ever been hospitalized for				,	allergic to or have you had any reactions to the following	owing?_	
operation or serious illness within the	1.5				nesthetics (e.g. Novocain)	L	4
If yes, please explain				Sulfa D	or any other Antibiotics		1
3. Are you taking any medication(s) incl	udina			Barbitur		Ē	j
non-prescription medicine?	-			Sedative	es		7
If yes, what medication(s) are you tak	king?			lodine Aspirin			=
					tals (e.g. nickel, mercury, etc.)		
4. Have you ever taken Fen-Phen/Redux				Latex Ru			
Have you ever taken Fosamax, Bonive medications containing bisphosphore		cer		Other_		. L	
6. Have you taken Viagra, Revatio, Cial					have a persistent cough or throat clearing not ed with a known illness (lasting more than 3 week	-12 F	7
in the last 24 hours?	is or cornira					S) · L	_
7. Do you use tobacco?				13. Women	only: pregnant or think you may be pregnant?	Г	7
8. Do you use controlled substances?					nursing?	Ē	j
9. Do you have or have you had any of	the following?			Are you	taking oral contraceptives?		
					, ,	V	
HI L DI - L D	Yes No	Disease			√es No ☐ Chest Pains	Y	es
High Blood Pressure		Disease	alar		Chest Pains Easily Winded	L	7
Heart Attack		ac Pacem					Η.
Rheumatic Fever		Murmur			Stroke	L	7
Swollen Ankles	Angir				Hay Fever/Allergies		_
Fainting/Seizures		ently Tire	d		Tuberculosis	L	
Asthma	Anem				Radiation Therapy	L	_
Low Blood Pressure	L Emph	ysema			☐ ☐ Glaucoma		_
Epilepsy/Convulsions	Canc	er			Recent Weight Loss	L	
Leukemia	Arthri	tis			Liver Disease	L	
Diabetes	☐ ☐ Joint	Replacem	nent or Implan	nt	Heart Trouble	L	
Kidney Diseases	☐ Hepa	titis/Jaun	dice		Respiratory Problems		
AIDS or HIV Infection	☐ Sexue	Illy Transr	mitted Disease		Mitral Valve Prolapse		
Thyroid Problem	Stome	ach Troub	oles/Ulcers		Other	[
Patient Dental Histo	ory						
					Date of Last Exam		
N CD C D C L III	TION		No		Dale of Last Exam	Y	es
Name of Previous Dentist and Loca		Voc	140				
		Yes		8 Do you	have frequent headaches?	Г	
Do your gums bleed while brushing of the state of th	or flossing?	Yes			have frequent headaches?		7
Do your gums bleed while brushing a Are your teeth sensitive to hot or colo	or flossing? d liquids/foods?	Yes		9. Do you	clench or grind your teeth?	[
Do your gums bleed while brushing of the control of the contr	or flossing? d liquids/foods? our liquids/foods?	Yes		9. Do you 10. Do you	clench or grind your teeth? bite your lips or cheeks frequently?	0	
 Do your gums bleed while brushing of Are your teeth sensitive to hot or color Are your teeth sensitive to sweet or so Do you feel pain to any of your teeth 	or flossing? d liquids/foods? our liquids/foods? ;?	Yes		9. Do you 10. Do you 11. Have yo	clench or grind your teeth? bite your lips or cheeks frequently? u ever had any difficult extractions in the past?	[] []	
 Do your gums bleed while brushing a Are your teeth sensitive to hot or cold Are your teeth sensitive to sweet or sa Do you feel pain to any of your teeth Do you have any sores or lumps in a 	or flossing? d liquids/foods? our liquids/foods? i? or near your mouth?	Yes		9. Do you 10. Do you 11. Have yo 12. Have yo	clench or grind your teeth? bite your lips or cheeks frequently? u ever had any difficult extractions in the past? u ever had any prolonged bleeding]]]]	
 Do your gums bleed while brushing of Are your teeth sensitive to hot or color Are your teeth sensitive to sweet or so Do you feel pain to any of your teeth Do you have any sores or lumps in or Have you had any head, neck or jaw 	or flossing? I liquids/foods? our liquids/foods? i? or near your mouth? v injuries?	Yes		9. Do you 10. Do you 11. Have yo 12. Have yo followin	clench or grind your teeth? bite your lips or cheeks frequently? u ever had any difficult extractions in the past? u ever had any prolonged bleeding g extractions?] [] [
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 Do your gums bleed while brushing of Are your teeth sensitive to hot or color Are your teeth sensitive to sweet or so Do you feel pain to any of your teeth Do you have any sores or lumps in or Have you had any head, neck or jaw Have you ever experienced any of the problems in your jaw? 	or flossing? I liquids/foods? our liquids/foods? i? or near your mouth? v injuries?	Yes		9. Do you 10. Do you 11. Have yo 12. Have yo followin 13. Have yo 14. Do you	clench or grind your teeth? bite your lips or cheeks frequently? u ever had any difficult extractions in the past? u ever had any prolonged bleeding g extractions? u had any orthodontic treatment? wear dentures or partials?]]]]	
 Are your teeth sensitive to hot or cold Are your teeth sensitive to sweet or so Do you feel pain to any of your teeth Do you have any sores or lumps in a Have you had any head, neck or jaw Have you ever experienced any of the problems in your jaw? 	or flossing? I liquids/foods? our liquids/foods? i? or near your mouth? v injuries?	Yes		9. Do you 10. Do you 11. Have yo 12. Have yo followin 13. Have yo 14. Do you If yes, d	clench or grind your teeth? bite your lips or cheeks frequently? u ever had any difficult extractions in the past? u ever had any prolonged bleeding g extractions? u had any orthodontic treatment? wear dentures or partials? ate of placement		
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1. Do your gums bleed while brushing a 2. Are your teeth sensitive to hot or cold 3. Are your teeth sensitive to sweet or sa 4. Do you feel pain to any of your teeth 5. Do you have any sores or lumps in a 6. Have you had any head, neck or jaw 7. Have you ever experienced any of the problems in your jaw? Clicking Pain (joint, ear, side of face) Difficulty in opening or closing Difficulty in chewing Authorization and Rele I certify that I have read and understand the knowledge. The above guestions have been	or flossing? d liquids/foods? our liquids/foods? in? or near your mouth? v injuries? e following	o the best	stand b	9. Do you 10. Do you 11. Have yo 12. Have yo followin 13. Have yo 14. Do you If yes, d 15. Have yo regardii 16. Do you my insurance corbenefits otherwise	clench or grind your teeth? bite your lips or cheeks frequently? u ever had any difficult extractions in the past? u ever had any prolonged bleeding g extractions? u had any orthodontic treatment? wear dentures or partials? ate of placement u ever received oral hygiene instructions ag the care of your teeth and gums? like your smile?	[[[] [] [] [] [] [] [] [] []	ier n
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1. Do your gums bleed while brushing of the problems in your jaw? Authorization and Relet Retrieved and understand the knowledge. The above questions have been that providing incorrect information and been tis dentity.	or flossing? It liquids/foods? Our liquids/foods? It? Our near your mouth? It injuries? The following Compared to the above information the accurately answered the adaptos to my here the dangerous to my child during the dangerous the	o the best I. I unders period of	trand by the profit of any structured from the profit of t	9. Do you 10. Do you 11. Have yo 12. Have yo followin 13. Have yo 14. Do you If yes, d 15. Have yo regardin 16. Do you my insurance cor benefits otherwise pay less than the services rendered X	clench or grind your teeth? bite your lips or cheeks frequently? u ever had any difficult extractions in the past? u ever had any prolonged bleeding g extractions? u had any orthodontic treatment? wear dentures or partials? ate of placement u ever received oral hygiene instructions ag the care of your teeth and gums? like your smile? Impany to pay directly to the dentist or dental group is a payable to me. I understand that my dental insural actual bill for services. I agree to be responsible for	[[[] [] [] [] [] [] [] [] []	ier n
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