	Yes / No
2. Are you under treatment now?	[ ] [ ]
3. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	[ ] [ ]
If yes, please explain	
4. Are you taking any medication(s) Including non-prescription medicine?	[ ] [ ]
If yes, what medication(s) are you taking?	
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	[ ] [ ]

	Yes / No
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	[ ] [ ]
7. Do you use tobacco or nicotine?	[ ] [ ]
8. Do you use controlled substances?	[ ] [ ]
9. Are you wearing contact lenses?	[ ] [ ]
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	[ ] [ ]
11. Women Only:	
a) Are you pregnant or think you may be pregnant?	[ ] [ ]
b) Are you nursing?	[ ] [ ]
c) Are you taking oral contraceptives?.	[ ] [ ]

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

	Yes / No		Yes / No		Yes / No
High Blood Pressure	[ ] [ ]	Heart Disease	[ ] [ ]	Chest Pains	[ ] [ ]
Heart Attack	[ ] [ ]	Cardiac Pacemaker	[ ] [ ]	Easily Winded	[ ] [ ]
Rheumatic Fever	[ ] [ ]	Heart Murmur	[ ] [ ]	Stroke	[ ] [ ]
Swollen Ankles	[ ] [ ]	Angina	[ ] [ ]	Hay Fever/ Allergies	[ ] [ ]
Fainting / Seizures	[ ] [ ]	Frequently Tired	[ ] [ ]	Tuberculosis	[ ] [ ]
Asthma	[ ] [ ]	Anemia	[ ] [ ]	Radiation Therapy	[ ] [ ]
Low Blood Pressure	[ ] [ ]	Emphysema	[ ] [ ]	Glaucoma	[ ] [ ]
Epilepsy / Convulsions	[ ] [ ]	Cancer	[ ] [ ]	Recent Weight Loss	[ ] [ ]
Leukemia	[ ] [ ]	Arthritis	[ ] [ ]	Liver Disease	[ ] [ ]
Diabetes	[ ] [ ]	Joint Replacement or Implant	[ ] [ ]	Heart Trouble	[ ] [ ]
Kidney Disease	[ ] [ ]	Hepatitis / Jaundice	[ ] [ ]	Respiratory Problems	[ ] [ ]
AIDS of HIV Infection	[ ] [ ]	Sexually Transmitted Disease	[ ] [ ]	Mitral Valve Prolapse	[ ] [ ]
Thyroid problems	[ ] [ ]	Stomach Troubles / Ulcers	[ ] [ ]	Other _____	[ ] [ ]

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes / No
1. Do your gums bleed while brushing or flossing?	[ ] [ ]
2. Are your teeth sensitive to hot or cold liquids/foods?	[ ] [ ]
3. Are your teeth sensitive to sweet or sour liquid/foods?	[ ] [ ]
4. Do you feel pain to any of your teeth?	[ ] [ ]
5. Do you have any sores or lumps in or near your mouth?	[ ] [ ]
6. Have you had any head, neck or jaw injuries?	[ ] [ ]
7. Have you ever experienced any of the following problems in your jaw?	
Clicking	[ ] [ ]
Pain (joint, ear, side of face)	[ ] [ ]
Difficulty in opening or closing	[ ] [ ]
Difficulty in chewing	[ ] [ ]

	Yes / No
8. Do you have frequent headaches?	[ ] [ ]
9. Do you clench or grind your teeth?	[ ] [ ]
10. Do you bite your lips or cheeks frequently?	[ ] [ ]
11. Have you ever had any difficult extractions in the past?	[ ] [ ]
12. Have you ever had any prolonged bleeding following extractions?	[ ] [ ]
13. Have you had any orthodontic treatment?	[ ] [ ]
14. Do you wear dentures or partials?	[ ] [ ]
If yes, date of placement _____	
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	[ ] [ ]

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 perod of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group 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/guardian if minor) Date

Doctor's Comments _____

_____

_____ Signature _____ Date _____