Patient Medical	History						
Physician	Office Phon	е		Date of Last Exam			
		Yes No		ou wearing contact lenses?	1	Yes	No
l . Are you under medical treatment now?			10 Arevo	ou allergic to or have you had any reactions to the follo	wino?		
2. Have you ever been hospitalized for an	y His de 1 - 4 5 2		Local	Anesthetics (e.g. Novocain)			
surgical operation or serious illness wi			Penic	illin or any other Antibiotics			
If yes, please explain				Drugs			
1 1 1 1			Barbi	turates			
3. Are you taking any medication(s)			Sedat	tives			
including non-prescription medicine?				e		Щ	L
If yes, what medication(s) are you taki	ng?		Aspir	in		\square	L
1 7 7 7			Any Λ	Metals (e.g. nickel, mercury, etc.)			_
4. Have you ever taken Fen-Phen/Redux?			Latex	Rubber			
5. Have you ever taken Fosamax, Boniva, A	-		11 Days	r (please list)outperfer (please list)outperfer (please)outperfer (please)outperfer (please)			
medications containing bisphosphonate			11. DO yo	ated with a known illness (lasting more than 3 we	obo)?		
6. Do you use tobacco?				atea with a known titriess (tasting more trian 3 we ten Only:	ERS):		
7. Do you use controlled substances?				e you pregnant or think you may be pregna	nt2		
			b) Are	e you nursing?		П	
8. Do you have or have you had any of th	e following?		c) Are	e you taking oral contraceptives?			
	Yes No		0) 1110	Yes No		Yes	No
High Blood Pressure	Heart Disease.			Chest Pains			
Heart Attack	Cardiac Pacer			Easily Winded			
Rheumatic Fever	Heart Murmun	·		Stroke			
Swollen Ankles	Angina			Hay Fever / Allergies			
Fainting / Seizures	Frequently Tir	ed		Tuberculosis			
AsthmaLow Blood Pressure	Anemia			Radiation Therapy			
Epilepsy / Convulsions	Emphysema Cancer			Glaucoma			
Leukemia	Arthritis			Recent Weight Loss			L
Diabetes	Joint Replacem	ent or Imr	olant	Liver Disease			
Kidney Diseases	Hepatitis / Jau	ndice		Heart Trouble			
AIDS or HIV Infection	Sexually Trans	mitted Dis	sease	Respiratory Problems			
Thyroid Problem	Stomach Troul			Mitral Valve Prolapse			_
Acid Reflux	☐ Osteoporosis			Other			
Patient Dental F	History						
Name of Previous Dentist and Locatio	~			Date of Last Exam			
		Yes No				Yes	No
1. Do your gums bleed while brushing o			8. Do yo	ou have frequent headaches?			
2. Are your teeth sensitive to hot or cold			9. Do yo	ou clench or grind your teeth?			
3. Are your teeth sensitive to sweet or so			10. Do yo	ou bite your lips or cheeks frequently?			
4. Do you feel pain to any of your teeth				you ever had any difficult extractions			
5. Do you have any sores or lumps in or				past?			
6. Have you had any head, neck or jaw				you ever had any prolonged bleeding			
 Have you ever experienced any of the f 	ollowing		follow	ving extractions?you had any orthodontic treatment?		Щ	
problems in your jaw?			13. Have	you had any orthodontic treatment?			
Clicking			14. Do yo	ou wear dentures or partials?			
Pain (joint, ear, side of face)			If yes,	date of placement			
Difficulty in opening or closing				you ever received oral hygiene instructions			
Difficulty in chewing			regard	ding the care of your teeth and gums?			
Authorization at	nd Release		16. Do yo	ou like your smile?	•		
	. J . L L	o the best	of mv knowle	edge. The above questions have been accu	ıratelv ar	nswer	red.
understand that providing incorrect is	nformation can be dangero	us to my h	realth. I auth	horize the dentist to release any informati	ion inclu	ding	the
nagnosis and the records of any treatr and/or health practitioners. I authorize	nent or examination renae e and request my insurance	rea to me e company	to pay direc	auring the period of such Dental care to t tly to the dentist or dental group insuran	nıra parı ce benefi	ty pay its	yors
therwise payable to me. I understand	that my dental insurance	carrier ma	y pay less th	eage. The above questions have been accumbering the dentist to release any information during the period of such Dental care to testly to the dentist or dental group insurant and the actual bill for services. I agree to be	e respon	sible	
payment of all services rendered on	my venaij or my depender	us.					
X							
Signature of patient (or parent/guar	dian if minor)			Date	?		
		,					
Doctor's Comments	2.4						
			(2)	y			