Patient Dental History

	Yes	No
1. Are you interested in improving your smile?	☐	☐
2. Are you interested in whitening your teeth?	☐	☐
3. Are you interested in replacing any missing teeth?	☐	☐
4. Do you have any old fillings or dental treatments that you are unhappy with?	☐	☐
5. Do your gums bleed while brushing or flossing?	☐	☐
6. Are you having any trouble with your teeth or gums?	☐	☐
7. Have you ever had any difficult extractions in the past?	☐	☐
8. Have you ever had any prolonged bleeding or problems healing following an extraction / dental treatment?	☐	☐

Patient Medical History

Physician ______________________ Office Phone ______________ Date of Last Exam ________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
blood thinner or aspirin?	☐	☐

Please list any medications that you are taking

____

____

____

	Yes	No
4. Do you use tobacco?	☐	☐
5. Do you use alcohol?	☐	☐
6. Are you allergic to any medications?	☐	☐
Local anesthetics? (e.g. novocaine)	☐	☐
Penicillin or other antibiotics?	☐	☐

please list ______________________________

	Yes	No
7. Have you ever been treated for osteoporosis?	☐	☐
8. Are you pregnant or think you may be pregnant?	☐	☐

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

	Yes	No
High Blood Pressure	☐	☐
Rheumatic Fever	☐	☐
Fainting/Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy/Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
AIDS or HIV infection	☐	☐
Thyroid Problem	☐	☐
Heart Problem	☐	☐

What kind? ______________________________

	Yes	No
Heart Murmur	☐	☐
Angina	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitus/Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stroke	☐	☐
Hay Fever/Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Liver Disease	☐	☐
Respiratory Problems	☐	☐
Taking blood thinners	☐	☐
Other	☐	☐

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 period of such Dental care to third party payors and/or health practicioners. 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 dependants.

X ______________________________

Signature of patient or parent if minor

Medical History Updates	