



Medical History

(Please check Yes or No)

Are you under a physician's care now? Yes No If yes, please explain
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain
Have you ever had a serious head or neck injury? Yes No If yes, please explain
Are you taking any medications, pills or drugs? Yes No If yes, please list
Have you ever taken medication for bone density or osteoporosis? Yes No If yes, please list
Do you use tobacco? Yes No
Do you use controlled substances? Yes No

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives: Yes No Nursing: Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs
Other If yes, please explain

PLEASE CHECK MARK ANY OF THE FOLLOWING THAT YOU HAVE OR HAVE HAD

- AIDS/HIV Positive Chest Pains Frequent Headaches Hypoglycemia Rheumatism
Alzheimer's Disease Cold Sores/Fever Blisters Genital Herpes Irregular Heartbeat Scarlet Fever
Anaphylaxis Congenital Heart Disorder Glaucoma Kidney Problems Shingles
Anemia Convulsions Hay Fever Leukemia Sickle Cell Disease
Angina Cortisone Medicine Heart Attack/Failure\* Liver Disease Sinus Trouble
Arthritis/Gout Diabetes Heart Murmur\* Low Blood Pressure Spina Bifida
Artificial Heart Valve\* Drug Addiction Heart Pace Maker\* Lung Disease Stomach/Intestinal Disease
Artificial Joint\* Easily Winded Heart Trouble/Disease Mitral Valve Prolapse\* Stroke
Asthma Emphysema Hemophilia Osteoporosis Swelling of Limbs
Blood Disease Epilepsy or Seizures Hepatitis A Pain in Jaw Joints Thyroid Disease
Blood Transfusion Excessive Bleeding Hepatitis B or C Parathyroid Disease Tonsillitis
Breathing Problem Excessive Thirst Herpes Psychiatric Care Tuberculosis
Bruise Easily Fainting Spells/Dizziness High Blood Pressure Radiation Treatments Tumors/Growths
Cancer Frequent Cough High Cholesterol Recent Weight Loss Ulcers
Chemotherapy Frequent Diarrhea Hives or Rash Renal Dialysis Venereal Disease
Rheumatic Fever\* Yellow Jaundice

If you checked yes to cancer, please detail: Type

When Medications/ treatment

DENTAL HISTORY

TO HELP US SERVE YOU BETTER, PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do you have specific dental problems or concerns?

When was your last dental visit? What was done?

Do your gums bleed? Have you been told you have periodontal disease? If yes, when? What was done?

How do you feel about your smile? Have you ever thought of changing/ improving your smile?

Do you snore? Does your snoring disturb others? Do you suffer from sleep apnea? Do you use a CPAP?

How do you feel about being here today?

I HAVE ACCURATELY COMPLETED THIS FORM AND I WILL NOTIFY THIS OFFICE OF ANY CHANGES IN MY MEDICAL OR DENTAL INFORMATION.

SIGNATURE RESPONSIBLE PARTY DATE