MEDICAL HISTORY
Please answer EACH question

1. Do you have, or have you had any of the following:

☐ Anemia	☐ Rheumatic Fever	☐ Fainting Spells or Seizures
☐ Heart Ailments	☐ Blood Diseases	☐ Heart Murmur
☐ High Blood Pressure	☐ Hepatitis, Jaundice, or Liver Disease	☐ Rheumatism or Arthritis
☐ Respiratory Disease	☐ Kidney Disease	☐ Head Injuries
☐ Tuberculosis	☐ Tumors or Growths	☐ Stomach Ulcers
☐ Nervous Disorders	☐ Radiation Treatment of Any Kind	☐ Venereal Disease
☐ Diabetes	☐ Allergies	☐ Epilepsy
☐ Excessive Bleeding	☐ Asthma or Hay Fever	☐ Stroke
☐ Hip or Joint Replacement	☐ Glaucoma	

1. Are you in good health? ☐ Yes ☐ No
2. Date of last medical exam _____
3. Have you ever been hospitalized? ☐ Yes ☐ No
   If so, what was the problem? _____
4. Are you taking any drugs or medication? ☐ Yes ☐ No
   If so, what? _____
5. Do you have any disease, problem or condition you think I should know about? _____
   _____
6. Do you have any disease or have you had a transplant operation that has depressed your immune system? ☐ Yes ☐ No
7. Have you ever taken Fen-Phen, Pondiman or Redux?
   ☐ If yes, circle one. ☐ No
8. Have had an allergic reaction to bananas? ☐Yes ☐No
9. Are you sensitive or allergic to any drugs? ☐Yes ☐No
   If so, please list _____
10. Do you snore? ☐Yes ☐No
11. Do wear a cardiac pacemaker? ☐Yes ☐No
12. Have you had heart surgery? ☐Yes ☐No
13. Are you now under care of M.D.? ☐Yes ☐No
14. Have you had any serious illness? ☐Yes ☐No
15. Blood pressure, if known? _____
16. Do you smoke? ☐Yes ☐No
    How much? _____

Physician's name _____
Address _____ Phone _____

FOR WOMEN ONLY

Are you taking birth control pills? ☐Yes ☐No Are you breast-feeding? ☐Yes ☐No
Are you pregnant? ☐Yes ☐No If yes, how long? ☐1 - 3 mos. ☐3 - 6 mos. ☐6 - 9 mos.

DENTAL HISTORY

1. How long since you've been to a dentist? _____
2. Reason for this visit? _____
   _____
3. How often do you floss your teeth? _____
4. Have you ever been treated for periodontal disease? ☐Yes ☐No
5. Have you had any complications from an extraction? ☐Yes ☐No
   If yes, explain _____
6. Have you ever had a popping or clicking near your ear when you chew? ☐Yes ☐No
7. Are you prone to frequent headaches? ☐Yes ☐No
8. Do you grind or clench your teeth? ☐Yes ☐No
9. Do your gums bleed when you brush? ☐Yes ☐No
10. Do you have sores, blisters, or swelling on your gums, lips or cheeks? ☐Yes ☐No
11. Have you ever had orthodontic treatment? ☐Yes ☐No
12. If I could change my smile I would make my teeth:
    ☐Whiter
    ☐Close space
    ☐Replace stained front filling
    ☐Change silver filling to white
    ☐Repair chipped teeth
    ☐Other _____

Previous Dentist _____ City _____ Phone( ) _____

REMARKS

IS THERE ANY ADDITIONAL MEDICAL OR DENTAL INFORMATION WE MAY NEED TO KNOW ABOUT BEFORE BEGINNING TREATMENT? _____

_____

CONSENT

Adult: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Minor: I, being the parent (or guardian) of the above named minor patient, do hereby authorize the performance of dental services upon this patient and whatever procedures the judgement of the doctor may dictate in order to carry out treatment procedures as outlined on the treatment plan form. I also authorize and request the administration of such anesthetics and/or sedatives as may be deemed advisable by the doctor.

I understand that my dental care insurance carrier or payor of my dental benefits may allow less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I agree to be responsible for payment of services not paid, in whole or in part, by my dental care payor.

I attest to the accuracy of the information on this page.

Date _____ Relative _____ Date _____

Signature _____ Signature _____