Name: _____ Date of Birth: _____

DENTAL INFORMATION

Date of your last dental examination? _____
What was done at the time? _____
How do you feel about the appearance of your teeth? _____

Do your gums bleed when you brush?	❒ Yes	❒ No	Are your teeth pressure sensitive?	❒ Yes	❒ No
Are your teeth heat sensitive?	❒ Yes	❒ No	Does your jaw lock when opening?	❒ Yes	❒ No
Are your teeth cold sensitive?	❒ Yes	❒ No	Do you grind or clench your teeth?	❒ Yes	❒ No

MEDICAL INFORMATION

Physician's Name: _____

Have you been under the care of a physician in the last two years?	❒ Yes	❒ No
Have you taken any medication or drugs in the past two years?	❒ Yes	❒ No
Are you presently taking any medications or drugs? List: _____	❒ Yes	❒ No
Have you ever had an allergic reaction to drugs or food? List: _____	❒ Yes	❒ No
Do you use or smoke tobacco products?	❒ Yes	❒ No
Are you sensitive to any metals?	❒ Yes	❒ No
Are you sensitive to latex?	❒ Yes	❒ No

INDICATE WHICH OF FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT:

Artificial Heart Valve	❒ Yes	❒ No	Cancer	❒ Yes	❒ No	Sexually Transmitted Disease	❒ Yes	❒ No
Heart Disease/Attack	❒ Yes	❒ No	Chemo/Radiation	❒ Yes	❒ No	A. I. D. S./ HIV	❒ Yes	❒ No
Angina Pectoris	❒ Yes	❒ No	Ulcers	❒ Yes	❒ No	Liver Disease	❒ Yes	❒ No
Congenital Heart Disease	❒ Yes	❒ No	Diabetes	❒ Yes	❒ No	Hepatitis A	❒ Yes	❒ No
Heart Murmur	❒ Yes	❒ No	Thyroid Problems	❒ Yes	❒ No	Hepatitis B	❒ Yes	❒ No
Rheumatic Fever	❒ Yes	❒ No	Fainting/Dizzy	❒ Yes	❒ No	Artificial Joints	❒ Yes	❒ No
Mitral Valve Prolapse	❒ Yes	❒ No	Tuberculosis	❒ Yes	❒ No	Drug Addiction	❒ Yes	❒ No
Heart Pacemaker	❒ Yes	❒ No	Asthma	❒ Yes	❒ No	Glaucoma	❒ Yes	❒ No
Heart Surgery	❒ Yes	❒ No	Arthritis	❒ Yes	❒ No	Kidney Problems	❒ Yes	❒ No
Fever Blisters/Cold Sores	❒ Yes	❒ No	Hayfever	❒ Yes	❒ No	Anemia	❒ Yes	❒ No
High Blood Pressure	❒ Yes	❒ No	Allergies/Hives	❒ Yes	❒ No	Osteopenia/Osteoporosis	❒ Yes	❒ No
Stroke	❒ Yes	❒ No	Sinus Trouble	❒ Yes	❒ No			
Hemophilia	❒ Yes	❒ No	Epilepsy Seizures	❒ Yes	❒ No			

Are you taking or have you ever taken Bisphosphates (e.g.: Fosamax, Actaonel, Boniva, Reclast)? ❒ Yes ❒ No
Have you taken the prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss product? ❒ Yes ❒ No
Please list any other condition, disease or problem not listed above: _____

FOR WOMEN:

Are you taking birth control pills?	❒ Yes	❒ No	
Are you pregnant?	❒ Yes	❒ No	What month? _____
Are you nursing?	❒ Yes	❒ No	

Consent:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

I, the undersigned, authorize the doctor and/or his representatives to compile the necessary information including the taking of x-rays, preparation of study models and/or the use of any other diagnostic aids required to make thorough diagnosis of my dental needs. I authorize the doctor to perform all recommended treatment agreed upon as well as to use the appropriate medication and therapy in connection with such treatment.

Patient/Guardian Signature _____ Date _____

Doctors Signature _____ Date _____