Patient Name: _____ **Date of Birth**: _____

DENTAL HISTORY

1. Is this your first visit to a dentist? ..... YES NO
2. Do you have dental pain, bleeding gums or sensitive teeth? ..... YES NO
3. Have you ever had an injury to your face or jaw, or do you have jaw pain? ..... YES NO
4. Have you ever had any problems associated with dental treatment..... YES NO
5. Do you brush and floss your teeth and mouth daily? ..... YES NO
6. Do you currently, or have you ever used tobacco products? ..... YES NO
   If yes, explain _____
7. Do you use fluoride tablets or rinses? ..... YES NO
8. What type of dental treatment do you feel you need? _____

MEDICAL HISTORY

The following information is necessary for you to receive dental treatment and will be completely confidential. Dental treatment will not be refused because of existing medical conditions.

1. Are you receiving any type of medical treatment or have you been hospitalized? ..... YES NO
2. Have you had a recent illness or surgery? ..... YES NO
3. Are you taking any prescription, non-prescription or herbal medications? ..... YES NO
   If yes, list them _____
   _____
4. Are you allergic to any medications or to latex? ..... YES NO
   If yes, list them _____
5. Have you ever had excessive bleeding requiring medical treatment? ..... YES NO
6. If female, are you pregnant? YES NO. If yes, when are you due? _____
7. List your medical provider's name and phone number _____

8. Indicate which of the following you have had or have at present. Please circle.

Alcoholism	Clotting Disorder	Heart murmur/Prosthetic Heart Valve	Osteoporosis/Bisphosphonate Drugs
Allergies	Congenital Heart Defect	Heart Endocarditis	Pacemaker
Anemia	Diabetes	History of blood transfusion	Seizures
Anxiety	Drug Addiction	HIV/AIDS	Sickle cell anemia
Arthritis/Joint disorder	Emphysema/COPD	Hypertension	Sinus problems
Asthma	ED Drug Therapy	Kidney Disease	STD
Autism	Fainting/Dizziness	Liver Disease/Hepatitis	Stomach ulcers
Broken Jaw	Glaucoma/Cataracts	Mental Health Disorder	Stroke
Cancer	Heart Disease/Surgery	Myocardial infarction (Heart attack)	Thyroid disease
Chest Pain/Angina	Heart Failure	Organ Transplant	Tuberculosis

9. Do you have any disease, condition or problem not listed above? YES NO Explain: _____

I certify that the information given is complete and correct. Any necessary treatment is hereby authorized.

Patient or Legal Guardian Signature _____ **Date** _____